United States v. State of Texas

Monitoring Team Report

Denton State Supported Living Center

Dates of Onsite Review: March 26th through 30th, 2018

Date of Report: DRAFT June 18, 2018

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Background

In 2009, the State of Texas and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with intellectual and developmental disabilities in state-operated facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. The Settlement Agreement covers the 12 State Supported Living Centers (SSLCs), Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo, and San Antonio, and the Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) component of the Rio Grande State Center.

In 2009, the parties selected three Independent Monitors, each of whom was assigned responsibility to conduct reviews of an assigned group of the facilities every six months, and to detail findings as well as recommendations in written reports that were submitted to the parties. Each Monitor engaged an expert team for the conduct of these reviews.

In mid-2014, the parties determined that the facilities were more likely to make progress and achieve substantial compliance with the Settlement Agreement if monitoring focused upon a small number of individuals, the way those individuals received supports and services, and the types of outcomes that those individuals experienced. To that end, the Monitors and their team members developed sets of outcomes, indicators, tools, and procedures.

Given the intent of the parties to focus upon outcomes experienced by individuals, some aspects of the monitoring process were revised, such that for a group of individuals, the Monitoring Teams' reviews now focus on outcomes first. For this group, if an individual is experiencing positive outcomes (e.g., meeting or making progress on personal goals), a review of the supports provided to the individual will not need to be conducted. If, on the other hand, the individual is not experiencing positive outcomes, a deeper review of the way his or her protections and supports were developed, implemented, and monitored will occur. In order to assist in ensuring positive outcomes are sustainable over time, a human services quality improvement system needs to ensure that solid protections, supports, and services are in place, and, therefore, for a group of individuals, these deeper reviews will be conducted regardless of the individuals' current outcomes.

In addition, the parties agreed upon a set of five broad outcomes for individuals to help guide and evaluate services and supports. These are called Domains and are included in this report.

Along with the change in the way the Settlement Agreement was to be monitored, the parties also moved to a system of having two Independent Monitors, each of whom had responsibility for monitoring approximately half of the provisions of the Settlement Agreement using expert consultants. One Monitoring Team focuses on physical health and the other on behavioral health. A number of provisions, however, require monitoring by both Monitoring Teams, such as ISPs, management of risk, and quality assurance.

Methodology

In order to assess the facility's compliance with the Settlement Agreement and Health Care Guidelines, the Monitoring Team undertook a number of activities:

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a facility's compliance with all provisions of the Settlement Agreement.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed.
d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, Positive Behavior Support Plan (PBSP) and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Monitoring Report** – The monitoring report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for

each individual are provided in tabular format. A summary paragraph is also provided for each outcome. In this paragraph, the Monitor provides some details about the indicators that comprise the outcome, including a determination of whether any indicators will be moved to the category of requiring less oversight. Indicators that are moved to this category will not be monitored at the next review, but may be monitored at future reviews if the Monitor has concerns about the facility's maintenance of performance at criterion. The Monitor makes the determination to move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the facility's plans for continued quality assurance and improvement. In this report, any indicators that were moved to the category of less oversight during previous reviews are shown as shaded and no scores are provided. The Monitor may, however, include comments regarding these indicators.

Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

a. **Domains:** Each of the five domains heads a section of the report.
b. **Outcomes and indicators:** The outcomes and indicators are listed along with the Monitoring Teams' scoring of each indicator.
c. **Summary:** The Monitors have provided a summary of the facility's performance on the indicators in the outcome, as well as a determination of whether each indicator will move to the category of requiring less oversight or remain in active monitoring.
d. **Comments:** The Monitors have provided comments to supplement the scoring percentages for many, but not all, of the outcomes and indicators.
e. **Individual numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers.
f. **Numbering of outcomes and indicators:** The outcomes and indicators under each of the domains are numbered, however, the numbering is not in sequence. Instead, the numbering corresponds to that used in the Monitors' audit tools, which include outcomes, indicators, data sources, and interpretive guidelines/procedures (described above). The Monitors have chosen to number the items in the report in this manner in order to assist the parties in matching the items in this report to the items in those documents. At a later time, a different numbering system may be put into place.

Executive Summary

At the beginning of each Domain, the Monitors provide a brief synopsis of the findings. These summaries are intended to point the reader to additional information within the body of the report, and to highlight particular areas of strength, as well as areas on which Center staff should focus their attention to make improvements.

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at Denton SSLC for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Teams during the onsite review. The Facility Director supported the work of the Monitoring Teams, and was available and responsive to all questions and concerns. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

Status of Compliance with the Settlement Agreement

Domain #1: The State will make reasonable efforts to ensure that individuals in the Target Population are safe and free from harm through effective incident management, risk management, restraint usage and oversight, and quality improvement systems.

This Domain currently contains 22 outcomes and 60 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, and mortality review. At the time of the last review, 12 of these indicators, including two entire outcomes, had sustained high performance scores and moved to the category requiring less oversight. Presently, one additional indicators will move to the category of less oversight, which represents the entirety of Outcome 4 in the area of abuse, neglect, and incident management. One indicator related to restraint will return to active oversight.

With the agreement of the parties, the Monitors have largely deferred the development and monitoring of quality improvement outcomes and indicators to provide the State with the opportunity to redesign its quality improvement system. Additional outcomes and indicators will be added to this Domain during upcoming rounds of reviews.

The identification and management of risk is an important part of protection from harm. Risk is also monitored via a number of outcomes and indicators in the other four domains throughout this report. These outcomes and indicators may be added to this domain or cross-referenced with this domain in future reports.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

<u>Restraint</u>
There continued to be low usage of restraint at Denton SSLC. The Center had the second lowest census-adjusted rate in the state. Even so, some work needs to be done to clarify the way injuries during restraint are counted. Also, regarding protective mechanical restraint for self-injurious behavior (PMR-SIB), the Center showed some good outcomes for one individual who's PMR-SIB was eliminated, but less positive outcomes for another individual for whom fading trials and data collection were not being implemented often or correctly enough.

Similar to the last review, crisis intervention physical restraints were, for the most part, handled correctly, but other types of restraint (crisis intervention chemical, PMR-SIB) were not handled and documented

correctly. This points to the need for the Center to focus upon making sure these other types of restraints receive proper implementation, documentation, review, and actions, when needed (i.e., proper management of restraint).

All staff the Monitoring Team interviewed answered all of the questions about restraint correctly. This was good to see and was an improvement compared to the previous two reviews.

There was only one crisis intervention chemical restraint during the entire review period. However, proper protocols were not followed, such as regarding notification and consultation with behavioral health services prior to administration. This was in August 2017. There was re-training of the protocols, and there have not been any occurrences of crisis intervention chemical restraint since then.

Video review of restraints was not being used for a lessons-learned experience. At many other Centers, videos of restraints are reviewed by a group of relevant Center staff.

Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: providing detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and assessing individuals for injuries and documenting the results.

Abuse, Neglect, and Incident Management

Staff-related antecedent actions occurred, and trends were reviewed. PBSPs, PSPs, and/or PNMPs to have reduced the likelihood of incidents occurring were in place for all but one individual.

However, for Individual #31, who died as a result of a choking incident, the Center's investigation showed that necessary supports were not in place/implemented. In addition, from the documentation submitted, the Monitoring Team could not determine whether or not the recommendations were implemented across campus, and if so, whether the Center tested their effectiveness. Based on the Monitoring Team's observations of mealtimes, many of the same concerns the Center identified in its investigation and/or that the investigation's recommendations should have remediated continued to place individuals at risk.

There was continued improvement and attention to detail, particularly in regard to the entries and content in the IMRT meeting minutes. Moreover, the Center clearly paid attention to some areas that were problematic at the last review, because improvement was seen this time. This includes the presence of the posters showing reporting information, the quality of the written UIRs, following required protocols for individuals identified by Health and Human Services Commission Provider Investigations (HHSC PI) for streamlined investigations (though HHSC PI was not following its own protocol for quarterly review), and alleged

perpetrator reassignment.

Audits of serious injuries, and investigations of discovered non-serious injuries (NSIs) continued to meet criteria. The Center continued the good practice of having the Assistant Independent Ombudsman validate whether planned follow-up actions occurred.

Even so, some incidents were not reported within the required one-hour time frame. For this review, one was reported about 30 minutes past the one-hour time limit, and the other was reported more than two hours after the incident occurred. Two investigations did not thoroughly collect and analyze data. For one, the cause of an injury was not properly classified. For the other, a variety of pieces of evidence were not gathered or analyzed.

Denton SSLC continued to regularly collect and review relevant incident- and allegation-related data. This was good to see and sets the occasion for ongoing quality improvement. Improvement was needed in the analysis of relevant data.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.											
Summary: There was low usage of restraint at Denton SSLC. The Center had the second lowest census-adjusted rate in the state. Both indicators scored higher than at the last review. Some work needs to be done to clarify the way injuries during restraint are counted. Regarding PMR-SIB, the Center showed some good outcomes for one individual who's PMR-SIB was eliminated, but less positive outcomes for another individual (Individual #173) for whom fading trials and data collection were not being implemented often or correctly enough. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	83% 10/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	70% 7/10	1/1	1/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1
Comments:											

1. Twelve sets of monthly data provided by the facility for the past nine months (May 2017 through January 2018) were reviewed. The overall usage of crisis intervention restraint at Denton SSLC remained low over the review period. A review of the nine months of data showed a slightly higher rate of occurrence than at the last review, but a descending trend across the current nine-month period. Note, however, that during this review period, physical escorts over active resistance and object retrieval over active resistance were added to the data. These additions were clearly marked on the nine-month graphs.

Moreover, Denton SSLC had the second lowest rate of crisis intervention restraint when comparing census-adjusted numbers across the 13 Centers. The rate of crisis intervention physical restraint paralleled the overall usage of crisis intervention restraints because most crisis intervention restraints were crisis intervention physical restraints. The average duration of a crisis intervention physical restraint decreased to about four minutes from six minutes at the last review. There was one occurrence of crisis intervention chemical restraint. The graph showed zero occurrences of crisis intervention mechanical restraint, however, the tier 1 document .13 listed two applications of a helmet (for one individual on the same day, most likely, during the same incident).

The number of injuries that occurred as a result of restraint implementation showed a decreasing trend and all were deemed non-serious by the behavioral health services department staff, however, see the Monitoring Team's more in depth review of this below under outcome 1-b. That being said, the QAQI report from 3/26/18 showed 41 restraint injuries (and 67 over the review period). This seemed to be due to the data set not differentiating between injuries that occurred during (or as a result of) restraint versus any injury that the individual had at the time of post-restraint assessment (i.e., it included injuries that occurred as a result of behavior problems that ultimately led to restraint, but that had occurred prior to restraint implementation). Therefore, there was inconsistency in the data sets presented to the Monitoring Team (i.e., the nine-month graph versus the QAQI report). This should be fixed. At the time of the last review there were other problems with the way restraint-injury information was being collected and tabulated.

The number of individuals who had one or more crisis intervention restraints each month was at about seven. The data set showed a slightly decreasing trend in the last two or three months, but when looking at the nine-month period, a decreasing trend was not evident. Two individuals had protective mechanical restraint for self-injurious behavior (PMR-SIB). During the review period, a third individual's PMR-SIB was successfully faded. This was good to see. There were no cases where a PMR-SIB device was incorrectly categorized as a protective/supportive device.

The use of non-chemical restraint and pretreatment sedation for medical and dental procedures was low. The use of TIVA remained high at more than 200 individuals per year.

Thus, facility data showed low/zero usage and/or decreases in 10 of the 12 facility-wide measures (overall use of crisis intervention restraint; use of crisis intervention physical, chemical, and mechanical restraint; duration of physical restraint; number of injuries during restraint; number of individuals with PMR-SIB; non-chemical restraint and pretreatment sedation for medical and dental procedures).

Denton SSLC's restraint reduction committee operated within the monthly trend review meetings. The information presented lots of data, but there was little in terms of analysis of the data, identification of problems areas, and/or suggested actions for improvement.

2. Eight of the individuals reviewed by the Monitoring Team were subject to restraint. In addition, the Monitoring Team reviewed restraint incidents for one additional individual (Individual #790) for a total of nine individuals. Five received crisis intervention physical restraints (Individual #115, Individual #96, Individual #157, Individual #159, Individual #25), one received crisis intervention mechanical restraint (Individual #790), one received PMR-SIB (Individual #173), one received escort (Individual #227), and one received object retrieval (Individual #274). Data from state office and from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for six (Individual #115, Individual #227, Individual #157, Individual #159, Individual #25, Individual #790). The other one individual reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period.

For Individual #173, the data showed an increase in use of PMR-SIB (i.e., in time of usage). A fading plan was in place, but implementation/ sessions were infrequent. Further, there was inconsistency in implementation and in data collection of self-injurious behavior. The Monitoring Team, for example, observed occurrences that were never recorded, staff with Individual #173 who did not have the paper sheet for recording data, and staff reports that frequent/rapid occurrences were not (could not) be counted and recorded.

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.	
Summary: Similar to the last review, crisis intervention physical restraints were handled correctly, but other types (crisis intervention chemical, PMR-SIB) were not handled and documented correctly. This points to the need for the Center to focus upon making sure these other types of restraints receive proper implementation, documentation, review, and actions, when needed (i.e., proper management of restraint). Therefore, indicator 8 will be returned to active monitoring. In general, restraint documentation was poorly organized making it difficult to review. Some were the result of initial IRIS implementation, which occurred at Denton SSLC in September 2017 (much later than at the other Centers). To the facility's credit, however, they were able to subsequently produce documentation when requested by the Monitoring Team. Indicators 5-7 and 9-11 will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	115	227	96	157	159	173	274	25	790
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	The restraint was a method approved in facility policy.										
5	The individual posed an immediate and serious risk of harm to him/herself or others.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	88% 7/8	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	N/A
7	There was no injury to the individual as a result of implementation of the restraint.	78% 7/9	1/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1	1/1
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. However, due to problems with implementation of crisis intervention chemical restraints and with PMR-SIB, this indicator will be returned to active monitoring.									
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/3	Not rated	Not rated	0/1	Not rated	Not rated	0/1	0/1	Not rated	Not rated
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	78% 7/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
The Monitoring Team chose to review nine restraint incidents that occurred for eight different individuals (Individual #115, Individual #227, Individual #96, Individual #157, Individual #159, Individual #173, Individual #274, Individual #25, Individual #790). Of these, five were crisis intervention physical restraints, one was a crisis intervention chemical restraint, one was a PMR-SIB, one was a physical escort, and one was an object retrieval. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

5. In general, there were problems with IRIS data input. The restraint manager reported that until recently, the drop-down menu allowed for three choices, but an update to IRIS now allowed for five choices, which now allowed for a better description of events. This problem in the data recording did not lead to any 0 scores for this indicator

because the Center provided the Monitoring Team with additional documentation showing the circumstances around the crisis intervention restraint.

For Individual #790 8/1/17, however, the information on the restraint checklist was too vague. While onsite, the Monitoring Team learned that proper protocols were not followed, such as notifying behavioral health services prior to implementation. In-services occurred following this event, which was in August 2017.

6. For Individual #173 PMR-SIB, the fading plan was not robust and implementation was inconsistent. Further, the data on self-injurious behavior were suspect because all instances were not being recorded. On the other hand, anecdotal reports from one staff were positive about Individual #173's progress.

7. As also noted in indicator 1 above, there were data inconsistencies between what the Center reported in tier 1 document .18 and in the QAQI report. The two that were scored 0 for this review were (a) Individual #173 who had a fracture in his hand in December 2017 while wearing the arm splints and (b) Individual #274 for whom the restraint documentation did not show an injury assessment (however, this was a discovered object retrieval incident that occurred shortly after object retrieval was added to the restraint category).

8. The Center was not doing a good job in implementing and documenting usage of PMR-SIB and crisis intervention chemical restraints. This was noted as a problem at the last review, too. Given that the Monitoring Team's direct observations while onsite, interviews with staff, and review of documentation showed improper, sloppy implementation of the PMR-SIB plan (Individual #173) and administration of crisis intervention chemical restraint when there was not imminent danger (Individual #790), one cannot rule out staff convenience.

9. Because criterion for indicator #2 was met for five of the individuals, this indicator was not rated for them. For the other three, there were problems with staff training and implementation of the PBSP, absence of sensory and communication needs being addressed, and medical issues that needed attention.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.

Summary: All staff interviewed by the Monitoring Team answered all of the questions about restraint correctly. This was good to see and was an improvement compared to the previous two reviews. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	227	96	157	159	173	274	25	790
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 6/6	1/1	1/1	1/1	Not rated	Not rated	1/1	1/1	Not rated	1/1

Comments:
12. Because criteria for indicators 2-11 were met for three individuals, this indicator was not scored for them. Staff for the other six individuals correctly answered all of the Monitoring Team's questions. This was good to see.

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.

Summary: Proper monitoring by the restraint monitor was not evident for crisis intervention chemical restraint, PMR-SIB (on one of seven days that were reviewed), and object retrieval. Attention to regular removal of PMR-SIB as required by indicator 14 was, however, being done as required. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	115	227	96	157	159	173	274	25	790
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	67% 6/9	1/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1	0/1
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	100% 1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A

Comments:
13-14. See comments above in the Summary box.

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.

Summary: Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: providing detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and assessing individuals for injuries and documenting the results. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overa	115	227	96	15	173	15	25	274	790

		II Score				7		9			
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	50% 4/8	0/1	0/1	1/1	1/1	N/A	0/1	1/1	0/1	1/1
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	33% 3/9	1/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	56% 5/9	1/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1	1/1

Comments: The nine restraints reviewed included those for: Individual #115 on 1/29/18 at 2:42 p.m.; Individual #227 on 1/31/18 at 1:22 p.m. [physical escort due to self-injurious behavior (SIB)]; Individual #96 on 1/14/18 at 6:35 p.m.; Individual #157 on 9/13/17 at 8:17 p.m.; Individual #173 from 1/8/18 to 1/14/18 (arm splints); Individual #159 on 9/25/17 at 10:32 p.m.; Individual #25 on 11/15/17 at 4:40 p.m.; Individual #274 on 10/19/17 at 7:30 p.m. (object removal); and Individual #790 on 8/1/17 at 9:45 a.m. (chemical).

a. through c. For Individual #157's physical restraint on 9/13/17 at 8:17 p.m., the nurse performed physical assessments, documented whether there were any restraint-related injuries or other negative health effects, and took action, as needed to meet the needs of the individual.

It also was positive that nursing staff conducted the necessary assessments and follow-up for the chemical restraint administered to Individual #790 on 8/1/17.

The following provide examples of problems noted:

- For Individual #115's physical restraint on 1/29/18 at 2:42 p.m., the documentation submitted did not address the individual's mental status.
- For Individual #227's physical escort due to SIB on 1/31/18 at 1:22 p.m., an Integrated Progress Note (IPN), dated 1/31/18 at 2:27 p.m., indicated that the assessment was not implemented timely. In addition, neither the IPN at 2:27 p.m. nor the IPN at 8:23 p.m. provided any indication that the nurse assessed the individual's mental status or assessed the individual for injuries.
- For Individual #96's physical restraint on 1/14/18 at 6:35 p.m., it was positive that nursing staff conducted the necessary physical assessments. However, an IPN, dated 1/14/18 at 6:50 p.m., noted an abrasion to his right knee and a scratch to his right leg, but did not indicate if these injuries were a result of the restraint procedure.
- For Individual #173's arm splints, the nursing IPNs did not clearly note that he used two arm splints (one for each arm), or that staff checked the splints daily to ensure that were in good working order. Moreover, nursing staff did not document daily circulation and skin integrity assessments of both arms. In addition, in the documentation provided, the Monitoring Team did not find direct support professional documentation of 30-minute checks to make sure that the splints were properly positioned and not too tight. Based on

interview with Center staff, direct support professionals were not documenting the 30-minute checks to ensure that the arm splints were not too tight or restricting Individual #173's circulation. A review of the documentation did not indicate when the individual was offered additional fluids, assistance to use the bathroom, and/or assistance with hygiene or other activities.

- For Individual #159 on 9/25/17 at 10:32 p.m., an IPN, dated 9/26/17 at 1:55 a.m., noted nursing staff were not notified of the restraint episode. Consequently, nursing assessments were not timely completed. Also, the nurse did not indicate whether or not the injuries noted in the IPN occurred as a result of the restraint procedure.
- For Individual #25's physical restraint on 11/15/17 at 4:40 p.m., it was positive that nursing staff conducted the necessary physical assessments. However, in the IPN, dated 11/15/17, the nurse did not indicate whether or not the injuries noted in the IPN occurred as a result of the restraint procedure.
- For Individual #274, the Restraint Checklist provided did not indicate that on 10/19/17, staff restrained the individual when the individual tried to kick and "hurt" staff with a butter knife that was retrieved from his right hand using PMAB. The initial date noted on the Checklist was 10/24/17, not 10/19/17. An IPN, dated 10/19/17, did not reflect a restraint episode and the Center's response to the document request for a Face-to-Face Debriefing form noted: "late Entry restraint No face to face." Thus, it was unclear if the individual was restrained on this date. In the IPN, the nurse noted the injuries occurred during the individual's behaviors, when staff told him he could not have a cigarette.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.

Summary: Documentation overall was very good. Nursing assessment documentation was missing from two of the seven days of PMR-SIB reviewed for Individual #173, and from the object retrieval incident with Individual #274. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	115	227	96	157	159	173	274	25	790
15	Restraint was documented in compliance with Appendix A.	78% 7/9	1/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1	1/1

Comments:
15. Documentation overall was very good. Nursing assessment documentation was missing from two of the seven days of PMR-SIB reviewed for Individual #173, and from the object retrieval incident with Individual #274.

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are

documented and implemented.											
Summary: Implementation of the IRIS system for restraint management occurred about mid-way through the nine-month review period. That, plus problems with management of crisis intervention chemical restraints as well as the additions of escorts and object retrieval, contributed to the low scoring on indicator 16. The Center was aware of these problems and planned to correct them going forward. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	227	96	157	159	173	274	25	790
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	56% 5/9	1/1	0/1	1/1	0/1	1/1	1/1	0/1	1/1	0/1
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments: 16. Review did not occur timely or at all at the unit and/or IMRT level for three of restraints (Individual #227, Individual #274, Individual #790). For Individual #157, documentation stated that restraint was not applied correctly when, however, it looked more like staff did implement the restraint correctly by immediately releasing her when she rolled to her stomach.											

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)											
Summary: There was one occurrence of crisis intervention chemical restraint in August 2017. Some aspects of its implementation were incorrect, including whether it should have been applied at all, and the use of multiple medications. Inservicing occurred and there were no subsequent occurrences. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	790								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within	100% 1/1	1/1								

	10 days post restraint.										
48	Multiple medications were not used during chemical restraint.	0% 0/1	0/1								
49	Psychiatry follow-up occurred following chemical restraint.	100% 1/1	1/1								

Comments:
47 and 49. These indicators applied to one individual, Individual #790. The initial review was performed by psychiatry within the required timeframe. Due to concerns that the use of the chemical restraint was not appropriate or justified, there was a second psychiatric review by the lead psychiatrist. The second review revealed commented regarding the lack of behavioral health assessment prior to use of chemical restraint, that the individual was reportedly no longer a danger by the time the chemical restraint was administered, and the use of three medications. The lead psychiatrist indicated a plan to inservice psychiatry. This was a good opportunity for the psychiatry staff to engage in quality assurance and corrective action. It was good that they were able to identify issues with their own practice and address them. Moreover, this occurred in August 2017 and there were no instances of crisis intervention chemical restraint from that time to the time of the onsite review.

48. The medications utilized during the event were a combination of Haldol, Ativan, and Benadryl. This combination of medications can cause significant medication side effects. It would be good for psychiatry to determine if a single agent medication would be effective in order to reduce the risk of medication interaction side effects.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.

Summary: Criteria were met for almost all of the investigations. The Center was now following SSLC protocols for individuals who frequently made false accusations; HHSC PI was not, however, following their own protocols. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	115	227	96	157	159	173	274	25	2
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	92% 11/12	2/2	2/2	1/1	1/1	1/1	0/1	2/2	1/1	1/1

Comments:
The Monitoring Team reviewed 12 investigations that occurred for nine individuals. Of these 12 investigations, nine were HHSC PI investigations of abuse-neglect allegations (two confirmed, four unconfirmed, one inconclusive,

one unfounded and streamlined, one administrative referral back to the facility). The other three were for facility investigations of serious injury fractures of rib and finger, and an unauthorized departure. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #115, UIR 18-021, HHSC PI 45563805/45563835, unconfirmed allegation of physical abuse, 9/26/17
- Individual #115, UIR 18-131, unauthorized departure, 2/6/18
- Individual #227, UIR 18-103, HHSC PI 46151108, confirmed allegation of physical abuse, 1/10/18
- Individual #227, UIR 18-115, HHSC PI 46222227, administrative referral of allegation of neglect, 1/21/18
- Individual #96, UIR 18-107, HHSC PI 46184928, unconfirmed allegation of neglect, 1/14/18
- Individual #157, UIR 18-038, HHSC PI 45645335, unconfirmed allegation of physical abuse, 10/15/17
- Individual #173, UIR 18-098, hand fracture, 12/30/17
- Individual #159, UIR 18-055, rib fracture, jumped from van, 11/7/17
- Individual #274, UIR 18-042, HHSC PI 45677913, unfounded allegation of verbal abuse, streamlined investigation, 10/19/17
- Individual #274, UIR 18-116, HHSC PI 46271435, sexual incident, 1/21/18
- Individual #25, UIR 18-056, HHSC PI 45789947, inconclusive allegation of physical abuse, 11/8/17
- Individual #2, UIR 18-070, HHSC PI 45894569, confirmed allegation of physical abuse, 11/28/17

1. For all 12 investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes (a) the occurrence of staff criminal background checks and signing of duty to report forms, (b) facility and IDT review of trends of prior incidents and related occurrences, and the (c) development, implementation, and (d) revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator and other facility staff met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

For all 12 investigations, the staff-related antecedent actions occurred, and trends were reviewed (though for nine of the 12, there were no trends because the investigation was solely about allegations of staff actions). For the remaining three incidents, all three met criteria with sub-indicator (b), which is about reviewing trends and history. Two of the three met criteria for sub-indicators (c) and (d). Some details are below:

- For Individual #115 UIR 18-131, the unauthorized departure behavior was reported to be a first time/isolated event. Nevertheless, the behavior was added to her PBSP and was being implemented; this was good to see.
- For Individual #159 UIR 18-055, the Center's risk analysis was adequate and these types of behaviors were addressed in her PSP and PNMP.

- For Individual #173 UIR 18-098, the PBSP and PNMP were not implemented sufficiently or correctly, and there was no evidence of effective changes to either plan.

Moreover, the investigation of the death of Individual #31 pointed to problems in implementation (and/or in determining if implementation occurred) regarding supports to reduce the likelihood of the individual choking and/or aspirating food. Please see additional information in the section of this report that addresses mortality review.

Nine individuals at Denton SSLC were designated by HHSC PI for streamlined investigations due to their making frequent calls that proved to be unfounded and that met HHSC PI's various criteria for inclusion on this list. This was the same number as at the time of the last review. The Monitoring Team looked to see if the HHSC PI and SSLC policies and protocols were being followed. Two individuals were chosen for review: Individual #274 and Individual #456. HHSC PI had not done quarterly reviews as required. The last one was in April 2017. This Center said that this was due to staffing changes at HHSC PI. The Center, however, was following protocols, including having the frequent calling behavior included in the individuals' PBSPs. This was an improvement since the last review.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.

Summary: Denton SSLC continued to have some incidents that were not reported within the required one hour time frame. For this review, one was reported about 30 minutes past the one-hour time limit, and the other was reported more than two hours after the incident occurred. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	115	227	96	157	159	173	274	25	2
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	83% 10/12	2/2	2/2	1/1	1/1	0/1	1/1	2/2	0/1	1/1

Comments:

2. The Monitoring Team rated eight of the investigations as being reported correctly. The other three were rated as being reported late or incorrectly reported. All were discussed with the facility Incident Management Coordinator while onsite. This discussion, along with additional information provided to the Monitoring Team, informed the scoring of this indicator.

Those not meeting criterion are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.

- For Individual #159 UIR 18-055, per the UIR, the incident occurred at 8:45 pm and was reported to facility director/designee at 10:08 pm.
- For Individual #25 UIR 18-056, HHSC PI showed that the incident occurred at 8:30 am, with notification to DFPS Statewide Intake at 10:49 am, and to facility director/designee at 10:08 am.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and serious injury reporting; receive education about ANE and serious injury reporting; and do not experience retaliation for any ANE and serious injury reporting.

Summary: It was good to see that the staff who were interviewed knew about ANE and reporting requirements. Similarly, it was good to see that the Center made improvements in posters and in staff knowledge of individuals, such that indicator 4 was scored at 100%. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	115	227	96	157	159	173	274	25	2
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 1/1	Not rated	Not rated	Not rated	Not rated	Not rated	1/1	Not rated	Not rated	Not rated
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
3. Because indicator #1 was met for eight of the individuals, this indicator was not scored for them. The indicator was scored for the other individual and criteria not met, that is, staff members who worked with this individual were able to correctly answer all of the Monitoring Team's relevant questions.

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.

Summary: The Center improved performance by ensuring alleged perpetrators were speedily re-assigned and the Center also improved its documentation of these actions. Given this improvement, with scoring returning to 100%, this indicator will be returned to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	115	227	96	157	159	173	274	25	2
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 12/12	2/2	2/2	1/1	1/1	1/1	1/1	2/2	1/1	1/1
Comments:											

Outcome 5– Staff cooperate with investigations.											
Summary: The Center made improvements compared with the last three reviews. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	227	96	157	159	173	274	25	2
7	Facility staff cooperated with the investigation.	100% 12/12	2/2	2/2	1/1	1/1	1/1	1/1	2/2	1/1	1/1
Comments:											

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
Summary: Two investigations did not thoroughly collect and analyze data. For one, the cause of an injury was not properly classified. For the other, a variety of pieces of evidence were not gathered or analyzed. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	227	96	157	159	173	274	25	2
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	83% 10/12	2/2	2/2	1/1	1/1	1/1	0/1	2/2	0/1	1/1
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by	83% 10/12	2/2	2/2	1/1	1/1	1/1	0/1	2/2	0/1	1/1

	other evidence was explained)										

Comments:

9-10. Two investigations did not meet criteria with these two indicators.

- Individual #173 UIR 18-098: The UIR concluded that there was a determined cause of the injury (self-injurious behavior), however, the Monitoring Team found no evidence in the UIR that would support this conclusion. To the contrary, there was a thorough investigation and a lot of evidence was obtained and reviewed (e.g., interviews, video review) that did not establish a cause. Therefore, not all evidence was properly analyzed. During discussion while onsite, the Center staff also agreed with this.
- Individual #25 UIR 18-056: HHSC PI concluded that there was insufficient evidence to determine a finding and found the allegation to be inconclusive. In its initial notification, OIG also found no evidence of criminal activity. But, in the Monitoring Team's review of the information in this case, not all relevant evidence was collected and analyzed. For instance, elements of the interview with the reporter could have been confirmed with video review, but weren't. Also, the HHSC PI investigator note stated that the video resolution was poor and, therefore, it could not be determined if a neck injury was present prior to his leaving his home or when he returned. This could have been pursued further by reviewing several days of injury reports and/or nursing notes (IPNs) to try and corroborate this conclusion. In addition, this should not have been an inconclusive finding because (a) the eyewitness who reported the incident had no apparent reason not to be truthful (this was not explored by the investigator) and (b) there were injuries that could have been caused from this incident. Overall, insufficient evidence was collected and analyzed to rule this out. OIG re-examined this incident and, after the Center's own investigation was complete, found likely evidence of criminal activity.

For Individual #2 UIR 18-070, there was a confirmation of physical abuse category 2 because the actions of staff could have caused harm to the individual. It was good to see this standard being applied.

Outcome 7– Investigations are conducted and reviewed as required.											
Summary: Denton SSLC continued to struggle to have all investigations completed within the required 10-day timeline. Further, a number of investigations did not show supervisory review that identified the types of topics/issues that were identified by the Monitoring Team. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	227	96	157	159	173	274	25	2
11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless	83% 10/12	2/2	1/2	0/1	1/1	1/1	1/1	2/2	1/1	1/1

	a written extension documenting extraordinary circumstances was approved in writing).										
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	67% 8/12	2/2	1/2	0/1	1/1	1/1	0/1	2/2	0/1	1/1

Comments:

12. For Individual #227 UIR 18-103, the investigation was completed on day 11 with no extension request. For Individual #96 UIR 18-107, the first interview did not occur until day 10 and the investigation was not completed until a few days later.

13. The expectation is that the facility's supervisory review process will identify the same types of issues that are identified by the Monitoring Team. Here, these were related to late reporting, alleged perpetrator re-assignment, absence of adequate extension requests, and/or reconciliation of possible staff actions related to the allegation and/or injury. Thus, a score of zero regarding these aspects in the indicators earlier in this section of the report does not result in an automatic zero score for this indicator. Identifying, correcting, and/or explaining errors and inconsistencies contributes to the scoring determination for this indicator.

The four incidents that did not meet criteria with this indicator were due to the supervisory review identifying late reporting or problems with the gathering and analyzing of evidence. In particular, for Individual #25 UIR 18-056, the supervisory review and subsequent facility investigation following the inconclusive finding were very thorough, but nevertheless missed some key points (e.g., OIG found enough evidence to find criminal activity). Furthermore, the UIR stated that the facility investigator did not find evidence to prove physical or verbal abuse. A facility investigation is not expected to necessarily prove an occurrence, only that it is more likely than not that something happened as described in the allegation. To a certain extent, an OIG confirmation might be enough input to result in a Director's confirmation.

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.

Summary:			Individuals:								
#	Indicator	Overall Score									
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									

15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	
Comments:		

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
Summary:			Individuals:								
#	Indicator	Overall Score									
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.										
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.										

Comments:

16. Recommendations for Individual #25 18-056 did not address the conflicting findings of HHSC PI (inconclusive) and OIG (criminal activity).

17. There were five investigations at Denton SSLC that included confirmations of physical abuse category 2. In all five of the cases, the employees' employment was not maintained.

18. Denton SSLC continued its excellent practice of having the Assistant Independent Ombudsman track and validate completion of investigation recommendations.

However, given the Monitoring Team's findings of ongoing problems in areas that the investigation's recommendations were designed to address, it was unclear whether or not many of the recommendations from the facility's investigation of the death of Individual #31 were implemented, or if so, if they had addressed to underlying cause of the problems.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.	
Summary: This outcome consists of facility indicators. Denton SSLC	Individuals:

continued to regularly collect and review relevant incident- and allegation-related data. This was good to see and sets the occasion for ongoing quality improvement. Given the performance improvements needed in incident management (as evidenced in the above outcomes and indicators), likely some corrective actions should have been identified. These indicators will remain in active monitoring.											
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes									
20	Over the past two quarters, the facility's trend analyses contained the required content.	Yes									
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	No									
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	No									
23	Action plans were appropriately developed, implemented, and tracked to completion.	No									
Comments: 21-23. Minutes from the monthly trends meeting showed actions completed and new actions. Expected outcomes, however, were not as clearly defined (data based) as they should be. For example, a new action was that there would be a campus wide refresher on I-SNIPP (related to incident actions and reporting). There really was no clear explanation (data based) of what the problem was that this campus wide refresher training was expected to solve.											

Pre-Treatment Sedation/Chemical Restraint

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331

a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	67% 2/3	N/A	N/A	1/1	N/A	N/A	1/1	N/A	0/1	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. Since the last review, it was positive that the Center had expanded and improved its policies with regard to criteria for the use of TIVA, as well as medical clearance for TIVA.

For three instances of the use of TIVA reviewed, medical clearance for TIVA was documented, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, and an operative note defined the procedures and assessments completed. For Individual #669 and Individual #256, documentation was present to show that they met the criteria for the use of TIVA, and nurses completed the required post-operative vital sign checks.

For Individual #416, nurses did not complete the full number of vital sign checks required (i.e., vital sign checks were submitted for only the first 22 minutes after TIVA). In addition, although this did not impact the scoring for this indicator, it was not clear whether or not he met the criteria for TIVA. More specifically, according to an ISPA, dated 6/21/17, the IDT recommended: "regular oral sedation should be attempted several times again to get more documentation and information before recommending use of IV sedation." Because this occurred outside the timeframe for the document request, it remained unclear whether or not these additional trials occurred.

b. Based on the documentation provided, during the six months prior to the review, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	33% 1/3	N/A	1/2	N/A	N/A	N/A	0/1	N/A	N/A	N/A

Comments: a. On 1/24/18, Individual #274 went for an off-site procedure at which medical staff administered intravenous (IV) sedation. Upon his return to the Center, nursing staff conducted vital sign checks consistent with current policy.

On 8/7/17, Individual #274 received Lorazepam 1 milligram (mg) by mouth (PO), but then refused to go to his scheduled appointment. On 12/20/17, Individual #256 received 2 mg Lorazepam for a lab draw. The Center did

not submit documentation for either of these individuals to show that the PCP obtained interdisciplinary input on the medication and dosage range. However, it was good to see that for both instances of pre-treatment medical sedation, informed consent was present, and nurses conducted pre- and post-sedation vital sign checks.

Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
Summary: Monitoring of this outcome and its indicators is put on hold while the State develops instructions, guidelines, and protocols for meeting criteria with this outcome and its indicators.			Individuals:								
#	Indicator	Overall Score									
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.										
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.										
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.										
4	Action plans were implemented.										
5	If implemented, progress was monitored.										
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.										
Comments:											

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overa	435	175	14	787					

		ll Score			5						
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 4/4	1/1	1/1	1/1	1/1					
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1					

Comments: a. Since the last review, eight individuals died. The Monitoring Team reviewed four deaths. Due to the fact that the Monitoring Team did not have access to Individual #31's clinical death review during the onsite review week, his death was not included in the scoring, but the Monitoring Team reviewed the information the Center provided after the site review, and provides some comments below.

The causes of death for the eight individuals who died were listed as:

- On 6/23/17, Individual #490 died at the age of 63 of severe left leg cellulitis, sepsis, and respiratory failure, "mental retardation," and epilepsy.
- On 9/22/17, Individual #175 died at the age of 53 of acute respiratory failure, pneumonia, septic shock, and acute renal failure.
- On 9/29/17, Individual #787 died at the age of 72 of pneumonia, and "mental retardation."
- On 11/6/17, Individual #145 died at the age of 65 of complications of ischemic perforation of the colon.
- On 12/28/17, Individual #435 died at the age of 58 of chronic respiratory failure.
- On 2/4/18, Individual #739 died at the age of 58 with causes of death pending.
- On 2/20/18, Individual #31 died at the age of 48 of aspiration of food.
- On 3/11/18, Individual #326 died at the age of 71 of cardiac arrest.

b. through d. Although the Center's mortality review process resulted in some needed recommendations, evidence was not submitted to show the Center conducted thorough reviews of nursing care, or an analysis of

medical/nursing reviews to determine additional steps that should be incorporated in the quality improvement process. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews. Some examples of problems include:

- Based on the reviews of Individual #175's death, Center staff missed the opportunity to provide clinical review of adrenal insufficiency, as well as the differential diagnosis of hyponatremia. In addition, the Center should have reviewed/revised its indications for transporting individuals via 911 or other options.
- Based on the reviews of Individual #145's death, Center staff missed the opportunity to provide clinical review of complications of a colostomy site.
- For each individual's death, the Center submitted a document entitled "Quality Improvement Death Review of Nursing Services." As discussed in the Monitoring Team's last report, these documents did not illustrate comprehensive reviews of the nursing supports provided to individuals. In addition, due to the lack of analysis of the information included in the reviews, the origin of many of the recommendations generated was unclear.

Although Individual #31's mortality review information was not assessed for the purposes of scoring, Monitoring Team members reviewed the documentation provided. According to the Center's investigation, Individual #31 died after choking on food that was not prepared to the correct texture. More specifically, he was at medium risk for choking due to eating too fast, taking large bites, and over filling his mouth. His diet texture was chopped. On 2/15/18, Individual #31 choked on a silver-dollar-sized beef tip. After initially patting him on the back when he exhibited signs of choking, staff made multiple attempts to utilize the abdominal thrust, and then cardiopulmonary resuscitation (CPR) until emergency medical staff (EMS) arrived. EMS removed the food that was lodged in his airway, and transported him to the hospital. He was placed on a ventilator at the hospital. On 2/20/18, after his mother signed a Do Not Resuscitate Order, the ventilator was removed. Individual #31 died due to cardiac/pulmonary failure.

Based on documentation the Center provided, the Clinical Death review included only three recommendations related to: 1) PSA screening on adult males; 2) guidelines related to reducing the cardiovascular risk of individuals with GERD/gastritis; and 3) guidelines related to the use of bisphosphonates in individuals with GERD/gastritis. The Center's investigation of the death included 15 substantive recommendations, many of which were important in light of the findings of the investigation. However, none of these were included in the Administrative or Clinical Death Reviews, and many of these recommendations were not measurable (e.g., Habilitation Therapies assigned to perform checks at meals in homes). In the State's comments on the draft report, Center staff asked the following question: "We review UIRs [Unusual Incident Reports] at the death reviews and do not reiterate these actions. To clarify the expectation, should we in the future reiterate actions listed on the UIR?" Because the Administrative and Clinical Death Reviews summarize the decisions of that group with regard to the acceptance or modification of recommendations from other death reviews (e.g., medical, nursing QI, etc.), it would be helpful to do the same for the UIR recommendations, or, at a minimum, reference the UIR recommendations and indicate whether or not the Committee accepted, rejected, or modified any of them (e.g., the UIR, dated ____, contained 15 recommendations, and the Committee accepted all 15 as written)." In addition, the Center(s) should submit

documentation showing completion of UIR recommendations in response to the Monitoring Team's request for follow-up information.

From the documentation submitted, it was unclear whether or not some of the investigation recommendations had been implemented across the campus (e.g., "All DSPs will receive a competency check by HT and retraining will occur as needed. Staff who do not pass the check will be retrained and if needed will not work in meals but can do training and care activities in the home until they are retrained and demonstrate competency."). If so, their effectiveness was questionable. Approximately a month after this incident occurred, the Monitoring Team found that staff followed individuals' dining plans during only six out of 25 mealtime observations (24%). Some examples of lapses included problems with the size/texture of food, staff encouraging individuals who were coughing to drink, staff not cuing individuals to alternate liquids and solids, individuals taking multiple bites without swallowing the food in their mouths, and individuals eating at unsafe rates.

In its comments on the draft report, the State indicated: "To clarify to the monitoring team, the training was implemented across campus for all DSPs and it was competency-based. The training included check offs for all the staff trained by habilitation therapies staff. We recognize the work needing to be done with meals but wanted to answer these questions noted in the draft report." Although the Monitoring Team did not have the opportunity to review documentation to show the completion of training, the Monitoring Team appreciates this clarification, the work done to complete the training, as well as the Center's acknowledgement that more work is needed.

In addition, none of the death reviews submitted for Individual #31 addressed some essential issues. For example, in the documents submitted, the Monitoring Team found no discussion regarding the quality of swallowing assessments, review of the PNMP monitoring system, and/or the quality of the implementation of the risk rating system. It was, for example, unclear why Individual #31's IDT rated him at medium choking risk when he had multiple swallowing and chewing difficulties that should have raised him to the level of high risk. Such a risk system was highly reactive, as the IDT appeared to rate him at medium risk due to his not having a choking incident in past 12 months. It appeared that Habilitation Therapy staff observed him twice during meals in response to a consult request for spillage. During both consultations, Habilitation Therapy staff noted that the effectiveness of the strategies to decrease his rate of intake was minimal, but offered no solutions to the issue. During a Dysphagia assessment in May 2017, his diet texture was downgraded from regular with chopped meat to all chopped, but the therapist did not make a recommendation to increase the level of his choking risk. In addition, the training Habilitation Therapy staff provided to direct support professionals regarding the Dining Plan was not competency-based, despite his having several interventions. The trainings provided were merely in-services.

e. The recommendations generally were not written in a way that ensured that Center practice had improved. For example, a recommendation related to Individual #145's death read: "Medical and Nursing staff should document timely." The response was in-service training for nurses and PCPs. This in no way ensured that concerning practices changed. The recommendation should have been written in a manner that required monitoring to determine whether or not improvements occurred with regard to timely documentation.

For some recommendations, the documentation submitted did not show completion of the required action steps. For example:

- For Individual #435, a recommendation read: “Documentation will be submitted to CF Director from ASPEN Hospice related to training/education completed with DSSLC staff.” The Center submitted hospice documents completed for this individual, but no training rosters were included to show that staff had completed in-service training.
- For Individual #787’s death, a recommendation read: “PNMC to discuss skin issues connected with new PEGs to determine if additional actions would be helpful and to implement and monitor any actions taken.” According to documentation submitted, at the Physical and Nutritional Management Committee on 1/4/18, the group reviewed research. The GI consultant was to review a template for an Acute Care Plan for new tubes. No further information was provided.

Domain #2: Using its policies, training, and quality assurance systems to establish and maintain compliance, the State will provide individuals in the Target Population with service plans that are developed through an integrated individual support planning process that address the individual's strengths, preferences, choice of services, goals, and needs for protections, services, and supports.

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the time of the last review, 14 of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, six additional indicators will move to the category of less oversight in the areas of ISP development, psychiatry, and psychology.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

Assessments

About half of the individuals in the behavioral health review group had significant trauma histories, but Center staff were not familiar with the concept of trauma informed care or the State Office initiative that was introduced to a year or so ago. In other words, the IDTs were aware of the individuals' histories, but did not have any awareness of how their histories might impact their current behaviors, much less drive treatment.

For many, but not all, individuals, the IDT considered and determined what assessments were needed (an improvement from previous reviews). But then, not all of them were obtained prior to the ISP meeting for any of the individuals.

In psychiatry, all individuals had a comprehensive psychiatric exam (CPE) and it contained all of the Appendix B sections. One-third of the CPEs had the required content. Annual updates were completed for all individuals, though most were missing one or more components.

In behavioral health services, about half of the behavioral health assessments were current. None of the assessments included a review of the individual's physical health from the previous year. Most individuals had a current functional behavior assessment. It was complete in content for about half of the individuals. Behavioral health services staff should be completing repeated observations of individuals in their homes and day program sites throughout the year. Treatment integrity and inter-observer agreement (IOA) assessments were not conducted monthly as indicated in policy.

About half of the individuals had current assessments related to skill acquisition, but content regarding skill acquisition was not included in any of the functional skills and vocational assessments. Vocational assessments were not comprehensive. Instead of providing direction and recommendations, they were largely a summary of past activities.

In order to assign accurate risk ratings in individuals' Integrated Risk Rating Forms (IRRFs), IDTs need to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings within no more than five days.

Although additional work was needed, the Center made progress with regard to the quality of medical assessments. Five of the nine individuals had quality annual medical assessments that included the necessary components and addressed individuals' needs. Moving forward, the Medical Department should focus on ensuring medical assessments include thorough plans of care for each active medical problem, when appropriate.

During this review, all nine individuals had timely annual dental exams and summaries. Good progress also was noted, and the Center should continue its focus on improving the quality of dental exams and summaries.

Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible. In addition, often, when individuals experienced changes of status, nurses did not complete assessments consistent with current standards of practice.

It was positive that as needed, a Registered Nurse (RN) Post Hospitalization Review was completed for the individuals reviewed, and the Physical and Nutritional Management Team (PNMT) discussed the results. Although IDTs continued to improve with regard to referring individuals to the PNMT, when needed, this is an area that requires continued focus. Of concern, a number of individuals who should have had comprehensive PNMT assessments did not. The Center also should focus on the quality of the PNMT comprehensive assessments.

Overall, it was positive that Occupational Therapists/Physical Therapists (OTs/PTs) completed timely assessments for the individuals reviewed. The quality of OT/PT assessments continues to be an area on which Center staff should focus.

Individualized Support Plans

There was improvement in the development of personal goals. Every individual had personal goals that met criteria in two or three different areas. This consistency across individuals was positive and now needs to be expanded to all areas, including to health/wellness/IHCP areas (the Monitoring Team is aware that State Office is working with the Centers on this).

The IDTs still relied heavily on Service Objectives as action plans to implement personal goals. This is one way to approach working towards goals, but at Denton SSLC, the service objectives were not formalized. Consider that each of individuals had about 20 service objective action plans, but none adequately described what needed to be done, who needed to do it, when/how often they needed to do it, and how data were to be collected.

As has been the case for some time, implementation and collection of data were not occurring as required. This must happen if progress is to be determined and for treatment changes to be made. Almost all individuals participated in their ISP meetings. However, none had a fully constituted IDT that participated in the annual planning meeting. During an annual ISP meeting that the Monitoring Team attended, the psychiatrist did a very good job of engaging with the individual and his family, describing the medications, and discussing the psychiatry/behavioral health status of the individual.

Denton SSLC made progress in developing psychiatry related goals for individuals and in identifying psychiatric indicators. Next steps are to make sure there is consistency in the goals across the psychiatric documents and to work on obtaining reliable data on the psychiatric indicators.

IDTs did not revise the ISPs as needed. QIDP monthly reviews provided minimal analysis regarding progress or outstanding needs. To address this, the Center Director and ADOP had been meeting with every QIDP to review the monthly data for one of the individuals on their caseloads. In addition, during the onsite review, the QIDP Coordinator participated in all of the QIDP interviews and had already begun to brainstorm strategies to address concerns that were raised.

- The Monitoring Team observed a positive related occurrence: One QIDP documented questioning the accuracy of the SAP monthly data, so she went to investigate. She spoke with staff, who said they did not know where to find SAP instructions and acknowledged they were just entering data without actually implementing the SAPs. She re-inserviced everyone and did a follow-up the following month.

In behavioral health, all individuals had goals. All of the goals were written in measurable terminology and were based upon assessments. The obtaining/collection of reliable data for these goals, however, remained a challenge and problem. This pivotal activity requires attention from the behavioral health services department.

Also in behavioral health, the PBSP for all but one of the individuals was current. None were considered complete in content, however, most components were present in most of the plans.

The behavior analysis resource center (BARC) remained in operation. During the onsite visit, the Monitoring Team met with the director regarding one individual's self-injurious behavior program (Individual #173). Several suggestions were discussed during this meeting. These and additional recommendations are in the report below.

Overall, the IHCPs of the individuals reviewed were not sufficient to meet their needs. Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs, as well as nursing and physical and nutritional support interventions.

ISPs/IHCPs still did not define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines.

Four of the nine individuals' PNMPs included all of the necessary components to meet the individuals' needs. With minimal effort and attention to detail, the Habilitation Therapy staff could make the needed corrections to PNMPs, and by the time of the next review, the Center could make good progress on improving individuals' PNMPs.

Performance decreased since the last review regarding the types of SAPs chosen for individuals. For instance, less than one-quarter of the SAPs were practical, functional, and/or meaningful. Collecting reliable SAP data also remained a challenge for Denton SSLC.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.	
Summary: There was improvement in the development of personal goals. Every individual had personal goals that met criteria in two or three different areas. This consistency across individuals was positive	Individuals:

and now needs to be expanded to all areas, including to health/wellness/IHCP areas (the Monitoring Team is aware that State Office is working with the Centers on this). Another area of focus is that once the personal goal area is determined, to write the goal in terminology that allows for the achievement/progress on the goal to be measurable. And lastly, as has been the case for some time, implementation and collection of data are required if progress is to be determined, for treatment changes to be made, and for the requirements of this outcome to be met. These indicators will remain in active monitoring.

#	Indicator	Overall Score	157	173	274	543	669	327			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	3/6	2/6	3/6	3/6	3/6	2/6			
2	The personal goals are measurable.	0% 0/6	1/6	1/6	1/6	1/6	1/6	1/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #157, Individual #173, Individual #274, Individual #543, Individual #327 and Individual #669. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Denton SSLC campus.

The ISP relies on the development of personal goals as a foundation. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

The IDTs continued to work toward developing measurable personal goals. For this review period, none of the six ISPs contained individualized goals in all areas, therefore, none had a comprehensive set of goals that met criterion. However, each of the ISPs contained an individualized goal in two or three different areas.

1. Sixteen personal goals met criterion as aspirational statements of outcomes, based on an expectation that individuals will learn new skills and have opportunities to try new things that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. This was a significant improvement from the previous monitoring visit, when seven goals met criterion Findings included:

The personal goals that met criterion were:

- Leisure goal for Individual #173 and Individual #327.
- Relationship goals for Individual #274, Individual #543, and Individual #669.
- Work goals for Individual #157, Individual #274, Individual #543, and Individual #669.
- Independence goal for Individual #157.
- Living options goals for all six individuals.

2. The Monitoring Team reviewed the 16 personal goals that met criterion for indicator 1 and their underlying action plans to evaluate whether they also met criterion for measurability. Of these 16 personal goals, six met criterion for measurability. Otherwise, the IDT often stated personal goals in broad terms without projecting a timeframe for, or a clear path toward, achievement. In such instances, the Monitoring Team also reviewed the action plans to assess whether these provided that needed measurability. Findings included:

- The IDT formulated many action plans as service objectives (SOs) or simply as descriptions of actions staff needed to complete. While some of these action plans were straightforward and indicated a single step needed with a projected timeframe for completion, many others required ongoing and successive implementation.
- The IDTs rarely developed service objectives with specific implementation methodologies and required data collection that would support measurability.
- Each of the six individuals in the ISP review had an average of 20 Service Objective (SO) action plans, but there was not a single formal SO implementation plan that described what needed to be done, who need to do it, when/how often they needed to do it and how data were to be collected.
- The Monitoring Team discussed this in detail with the QIDPs and QIDP Coordinator. It was positive the QIDP Coordinator immediately began to develop a plan to address this need. The Monitoring Team looks forward to seeing the outcomes of this strategy at the next visit.

3. For the six personal goals that met criterion in indicator 2, none had reliable and valid data.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and

achieve personal outcomes.											
Summary: This set of indicators speaks directly to the overall quality of the ISP and to score these indicators, the Monitoring Team looks across the entire ISP. Criteria were not met for any individual for any of the indicators. Many examples are provided in the comments below. In some cases, the IDTs made some good initial steps, but then either never followed-up or never implemented recommendations or plans, respectively. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	157	173	274	543	669	327			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
1	Each ISP action plan provided sufficient detailed	0%	0/6	0/6	0/6	0/6	0/6	0/6			

8	information for implementation, data collection, and review to occur.	0/6									

Comments:
As Denton SSLC further develops more individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals, and thus, the facility can achieve compliance with this outcome and its indicators.

8. For the most part, this group of individuals did not have personal goals that met criterion, as described under outcome 1 above (i.e., indicators 1-3). IDTs needed to focus on laying out a clear path of assertive action plans to meet each goal. Some goals had no related action plans, while others were only minimally or tangentially related to the achievement of the goal.

9. None of six ISPs contained a set of action plans that clearly integrated preferences and opportunities for choice in an assertive manner. IDTs demonstrated some increased proficiency in developing action plans that integrated preferences, but offered few opportunities for choice making. Findings included:

- Individual #173's ISP included a leisure goal for going to the grocery store, which was his preference, but the action plans only provided for doing it once a month. His ISP included another action plan to be given a choice of appropriate food items, but the IDT did not develop an implementation plan or methodology for teaching choice making skills or for data collection to measure progress.
- Individual #274's positive behavior support plan (PBSP) included strategies to increase choice making, which was positive, but the IDT had not identified and addressed his preferences in a meaningful way. Overall, the IDT's approach had instead been to restrict preferences as a means of gaining compliance. This had been largely unsuccessful.
    - It was positive the IDT had begun in the last few weeks to develop more of a focus on what was important to him and how to use more positive reinforcement. This should be continued.
- Individual #543's ISP identified some opportunities for choice making, but did not develop action plans that supported implementation. For example, he had an action plan to order from a menu, but the IDT did not provide an implementation plan with staff instructions for promoting choice or taking data related to his ability to make choices for himself. In another example, the ISP narrative indicated the IDT would offer informal opportunities to make choices about the types of music he would like to obtain, including at volunteer services and by making trips to stores. The IDT did not develop implementation plans for either of these. Data indicated he went to volunteer services but provided no evidence this opportunity was used to offer choice. The remaining action plan to go to stores to choose music had not been implemented.

10. None of six ISPs clearly addressed strengths, needs, and barriers related to informed decision-making. The IDTs had not developed such action plans for these six individuals.

11. None of six ISPs met criterion for supporting overall independence. The IDTs did develop some action plans to support independence, but did often did not address identified needs in this area in an assertive manner.

Examples included:

- The IDT did develop some skill acquisition plans (SAPs) for Individual #157, but not all of them focused on skill building in a functional manner. One of his SAPs, for money management, called for him to combine a quarter and a penny to total 26 cents, which did not address his more functional, higher level learning needs. Another, to clean up his work area, simply required compliance rather than skill building. The IDT did not take advantage of its good work during his ISP Preparation meeting that identified many independence needs, such as hygiene skills, budgeting skills, writing skills, food shopping, safe food handling, kitchen safety, how to measure, etc. These would have supported his personal goal to live in his own apartment.
- The IDT for Individual #274 also developed some skill acquisition action plans, such as doing laundry and counting change, but did not address many other needs it had identified to support his goal to live independently. These included, for example, cooking (which was also one of his preferences), reading, and making healthy food choices.
- Being able to communicate wants and needs is one of the most fundamental means of asserting independence. The IDTs for Individual #173, Individual #543, and Individual #327 did not assertively address their communication needs.

12. The IDTs did not assertively address risk areas in a consistent manner. At the time of the last visit, the Monitoring Team expressed concern about the rigor with which IDTs addressed risk assessment and mitigation, especially for falls and weight, noting that the PNMT did not take an active role in helping the IDTs complete the corresponding assessments and root cause analyses that should have been the basis for intervention and/or prevention. IDTs were unsure of the criteria for PNMT involvement and proactive clinical judgment was not being exercised when determining the need for formal PNMT assessment and engagement. At that time, we recommended the Center consider whether a formal CAP is needed in this area.

Findings for this visit included:

- The Monitoring Team remained concerned in this area, based on the lack of a comprehensive falls assessment for Individual #669 and Individual #327. Both had many falls and, although the IDTs had met with PNMT staff and made some effort to discover root cause, no one had completed a thorough and comprehensive falls analysis. In addition, the Center did not yet have a falls-tracking system that produced reliable data. The Quality Assurance (QA) Director reported the Center had not completed a formal CAP, but had taken some actions to address these needs. These included having the Habilitation Services Director track falls by cross-referencing various reports and documents.
    - Still, for Individual #327, the falls data provided by the Center from their database did not include two of four falls that occurred in a recent month. The QA Director also reported the Center had begun conducting root cause analysis meetings in January, which was a positive step.
    - Still, these were not yet effective, as evidenced by two such meetings held for Individual #669 that identified the same root cause, but which had not led to any significant reduction in falls. This could be at least partially attributed to the fact that a thorough and comprehensive falls analysis had not

been conducted.

- Three of six people (Individual #157, Individual #173, Individual #274) had significant trauma histories, but Center staff were not familiar with the concept of trauma informed care or the State Office initiative in that area introduced a year ago. The IDTs were aware of the histories, but did not have awareness of how they might impact behaviors, much less drive treatment.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well-integrated, also as described throughout this report. In addition to the examples provided in #12 above, the IDTs did not assertively address changing communication needs. Examples included:

- Per the ISP Preparation documentation for Individual #274, the IDT requested the speech/language pathologist (SLP) to address his reading needs, but this had not occurred. ISP action plans called for a speech assessment for reading menus, to select healthy eating choices, and overall functional reading skills, but this had not been implemented.
- Individual #543's IDT did not assertively address his behavioral/communication needs. The behavioral health assessment (BHA) indicated Individual #543 used vocalizations to communicate wants and needs. The PBSP required staff to work their way through a list of possibilities, offering them sequentially until he responded affirmatively. The IDT knew that he could order items from a picture menu, but did not consider developing a similar picture menu of wants/needs that could have allowed Individual #543 to point to a requested item or action. It was also not clear why attempts at AAC had been discontinued due to a reported lack of interest, yet he was still working still working on pushing a button to play a CD. Interest in the latter activity would indicate using AAC might still be possible if the IDT could identify more interesting purposes or methodologies.

14. Meaningful and substantial community integration action plans were largely absent from the ISPs for these six individuals, with no specific, measurable action plans for community participation that promoted any meaningful integration. Examples included:

- Individual #274's IDT did not develop action plans that would have taken advantage of opportunities for participation and integration that built upon his positive experiences in the past. For example, he had worked in a community gym while in high school and could have benefited from action plans to go to a gym for work and/or exercise. The IDT could also have developed action plans for attending a local church where his former foster father was pastor. The IDT had discussed that Individual #274 would like to sing in a church choir, which could have promoted even more integration.
- Both Individual #327 and Individual #669 had goals to participate in community arts/crafts classes and to make a friend in that environment. Making a friend could have elevated the outcome from one of simple participation to a means for community integration. Unfortunately, neither ISP had a specific, measurable action plan that supported the development of friendships.

15. None of six ISPs considered opportunities for day programming in the most integrated setting consistent with

the individual's preferences and support needs. Examples of those that did not meet criterion included:

- Individual #157 had a personal goal to work at a game store in the community. The IDT did not develop assertive action plans to support this goal. To the contrary, the IDT developed an action plan that created a barrier to community employment by requiring compliance with work on-campus (work that he did not like) before he could be assessed for his preferred community employment.
- The IDT had not assertively addressed Individual #543's clear interest in working at the Wooden Nickel, where he liked to assist with stacking and unstacking chairs. He frequently showed up independently at the appropriate time to take part in this activity. His ISP did not develop any related action plan. The IDT discussed that a referral for employment had been made and indicated if a trial of employment was not available, a request for an evaluation of work preferences would be submitted. The IDT did not develop an action plan for this and no work trial or evaluation had been completed. At his ISP observed by the Monitoring Team while onsite, the Monitoring Team saw a continued lack of IDT assertiveness and discouraging responses made by vocational staff who were in attendance at the meeting.
- The ISP for Individual #669 identified a personal goal for volunteering at an animal shelter. This was an appropriate personal goal based on her interests, but the action plans did not lay out a clear path for achieving the goal. The vocational and day program assessments did not provide any strategies for supporting its implementation.

16. None of six ISPs had substantial opportunities for functional engagement described in the ISP with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Overall, the ISPs provided limited opportunities for learning and functional engagement.

The Monitoring Team found this was particularly true in the area of work and other meaningful day activities.

As was the case for a number of other indicators, the reliance on SOs that did not have clear implementation plans impacted the level of functional engagement.

17. The IDT did not consistently address barriers to achieving goals. Overall, IDTs did not effectively address barriers to community transition with individualized and measurable action plans as described below in Indicator 26 and did not consistently address barriers to lack of implementation of the ISP. Other findings included:

- It was positive Individual #173's IDT addressed some of the barriers that prevented implementation of his leisure goal to go grocery shopping before continuing that goal into a second ISP. But even so, the IDT did not have an assertive vision for helping this young man return to live with his parents in their home, a goal the parents were eager to see fulfilled. The IDT did not address his behavioral barriers for fading arm splints being used to prevent self-injurious behavior with an intensive plan. The IDT had also not implemented assertive action plans for his communication barriers.
- It was positive Individual #327's IDT had addressed some of the barriers that had prevented implementation of his participation in a community arts and crafts class the year before, but it still took four months from the time of his ISP until the IDT arranged his first opportunity to attend. The IDT also did not

assertively address barriers for work, communication, and living options.

18. ISPs did not consistently include collection of enough or the right types of data to make decisions regarding the efficacy of supports. SAPs were often missing key elements and data had not been demonstrated to be valid or reliable, as described elsewhere in this report. Living options action plans often had no measurable outcomes related to awareness. In addition, as described under Indicator 2, IDTs relied on SOs or other staff actions for the bulk of ISP implementation, but had not developed any SOs with specific implementation methodologies.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.

Summary: Performance remained about the same as at the last review, with three indicators scoring a little higher and with others remaining at low performance. Some areas for focus within this outcome are in the depth of the living options discussion and in laying out some actions to address barriers to referral, or even a consideration of referral. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	157	173	274	543	669	327			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	67% 4/6	1/1	1/1	1/1	0/1	0/1	1/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	33% 2/6	1/1	1/1	0/1	0/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
2	The ISP defined a list of obstacles to referral for	83%	1/1	1/1	1/1	0/1	1/1	1/1			

4	community placement (or the individual was referred for transition to the community).	5/6									
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A			
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:

19. Four of six ISPs (for Individual #157, Individual #173, Individual #274 and Individual #327) included a description of the individual's preference for where to live and how that was determined. The IDT was not able to reliably describe the preferences for Individual #543 and Individual #669 due to their lack of exposure to, and awareness of, community living options.

20. Individual #543 had an annual ISP meeting during this onsite visit. The LIDDA and IDT indicated his preference was unknown, based on a lack of exposure to community living options. The LIDDA staff surmised he might like to live with his family and have his own room, but offered no evidence about how this was determined.

21. Two of six ISPs fully included the opinions and recommendation of the IDT's staff members. Findings included:

- Assessments often provided a statement of the opinion and recommendation of the respective team member. This was good to see. Exceptions included the following:
  - The BHA for Individual #327 provided a statement indicating he could live in the community, but offered no recommendation.
  - The BHA for Individual #669 stated she could live in the community, but did not recommend due to her deceased LAR's wishes. The disciplines should make a professional recommendation in the assessment. The annual medical assessment (AMA) did not make a clear statement and did not provide a recommendation. The vocational assessment did not include a statement or a recommendation.

- ISPs did not yet consistently include independent recommendations from each staff member on the team that identified the most integrated setting appropriate to the individual's need. For example, for Individual #543, the IRIS format did not specify the opinions of all disciplines.

22. This indicator met criterion. Six of six ISPs included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.

23. None of six individuals had a thorough examination of living options based upon their preferences, needs, and strengths. The ISPs did not reflect a robust discussion of available settings that might meet individuals' needs.

24. Five of six ISPs met criterion and identified a thorough and comprehensive list of obstacles to referral in a manner that would allow for the development of relevant and measurable goals to address the obstacle. For Individual #543, the IDT did not identify the lack of individual awareness, but should have.

25. The Monitoring Team observed Individual #543's annual ISP meeting during this onsite visit. The IDT did not have a thorough discussion of barriers to community living.

26. None of six individuals who were not referred had individualized, measurable action plans, with learning objectives or outcomes to address obstacles to referral. Findings included:

- IDTs did not specify learning or awareness outcomes or plan to collect data to evaluate awareness for any of the three individuals (Individual #543, Individual #327, Individual #669) for whom this was a barrier.
- For three individuals (Individual #157, Individual #173, Individual #274), the IDTs identified behavioral and psychiatric needs as the barrier, but did not state specific behavioral and psychiatric goals the individual would need to achieve to make community living feasible.

27. The Monitoring Team observed Individual #543's annual ISP meeting during this onsite visit. It was positive the IDT encouraged the LAR to think about what a "plan B" might look like for community living if the Center were not available for some reason. The LAR's response was that was a good idea she had not thought of before. The IDT should have used this opportunity to broach possible action plans for education about living options, but did not.

28. None of six ISPs had individualized and measurable plans for education.

29. Six of six individuals had obstacles identified at the time of the ISP.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.	
Summary: Individuals attended their ISP meetings for all but one individual in this review and the last set of reviews, too. Therefore, indicator 33 will be moved to the category of requiring less oversight.	Individuals:

Ensuring full attendance from IDT members and then implementing the action plans are areas for focus by the IDT, clinicians, and residential and day departments. Those two indicators (32, 34) will remain in active monitoring.

#	Indicator	Overall Score	157	173	274	543	669	327			
30	The ISP was revised at least annually.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.										
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	83% 5/6	1/1	0/1	1/1	1/1	1/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

32. ISPs were not consistently implemented on a timely basis, within 30 days of the ISP meeting, for any of six individuals.

33. Five of six individuals participated in their ISP meetings. Individual #173 refused to participate.

34. None of six individuals had an appropriately constituted IDT that participated in the planning process, based on their strengths, needs, and preferences. Examples included:

- For Individual #274, the primary care physician (PCP) and psychiatrist did not attend, but he had significant health and psychiatric concerns. Neither an occupational therapist (OT) nor physical therapist (PT) attended, but Individual #274 had a high risk for fractures and required OT supports following the fracture of his humerus in June 2017.
- Individual #543 had a physical and nutritional management plan (PNMP) and wore an ankle foot orthosis (AFO), but neither an OT nor PT attended. In addition, vocational staff did not participate, even though Individual #543 had a work goal and pending referral for work evaluation.

Outcome 6: ISP assessments are completed as per the individuals' needs.

Summary: For many, but not all, individuals, the IDT considered and determined what assessments were needed (an improvement from previous reviews). But then, they were not all obtained prior to the ISP meeting. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	157	173	274	543	669	327			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	67% 4/6	1/1	1/1	1/1	1/1	0/1	0/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting, for four of six (Individual #157, Individual #173, Individual #274, Individual #543) individuals. The IDTs for both Individual #327 and Individual #669 should have requested a comprehensive falls assessment, but did not.

36. IDTs did not consistently arrange for and obtain needed, relevant assessments prior to the IDT meeting. None of six ISPs met criterion. Examples of those that did not included:

- For Individual #173, the IDT did not obtain an updated BHA; the available assessment was dated 1/9/17, which was a few days from being a year old at the time of his ISP and did not reflect the activity and progress over that year. The SLP assessment was not dated until 1/4/18, the day after ISP meeting.
- For Individual #274, the ISP Preparation meeting requested an SLP screening to address recommendations to improve literacy skills (reading and counting) and how to remember choir music, but the assessment did not address these issues.
- For Individual #669, the last comprehensive SLP assessment occurred in 2012, and the IDT did not give a rationale for providing only a screening. Neither the vocational or day program assessments addressed needs related to her personal goal for volunteering at animal shelter.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.	
Summary: Progress was not adequately being reviewed by QIDPs and IDTs. Consequently, actions were not developed or taken. Though, a positive example was observed with one of the QIDPs as noted below in the comments. These two indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	157	173	274	543	669	327			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments: Overall, consistent implementation and monitoring of ISP action steps continued to be areas of significant concern. The Center Director and ADOP had been meeting with every QIDP to review the monthly data for one of the individuals on their caseloads.

The Monitoring Team observed a positive result from that process: One QIDP documented questioning the accuracy of the monthly data, so she went to investigate. She spoke with staff, who said they didn't know where to find SAP instructions and acknowledged they were just entering data without actually implementing the SAPs. She re-inserviced everyone and did a follow-up the following month.

37-38. IDTs did not revise the ISPs as needed, as evidenced throughout this section and others. This reflected negatively on the role of the QIDP to ensure individuals received required monitoring/review and revision of treatments, services, and supports.

- QIDP monthly reviews provided minimal analysis regarding progress or outstanding needs.
- For all individuals, most action plans for personal goals had been infrequently implemented, if at all. As noted throughout this section, ISPs often included SOs that did not have specific implementation methodologies and this contributed to the lack of implementation.

Outcome 1 – Individuals at-risk conditions are properly identified.											
Summary: In order to assign accurate risk ratings, IDTs need to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings within no more than five days. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	The individual's risk rating is accurate.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	22% 4/18	0/2	1/2	0/2	0/2	0/2	1/2	0/2	1/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 17 IRRFs addressing specific risk areas [i.e., Individual #157 – weight, and skin integrity; Individual #274 – fractures, and gastrointestinal (GI) problems; Individual #669 – falls, and constipation/bowel obstruction; Individual #86 – urinary tract infections (UTIs), and skin integrity; Individual #327 – falls, and other: osteoarthritis; Individual #256 – choking, and constipation/bowel obstruction; Individual #435 – skin integrity, and UTIs; Individual #416 – constipation/bowel obstructions, and GI problems; and Individual #331 – falls, and weight].

a. When determining a risk level, most IDTs appeared to use the risk guidelines, but none of the IDTs effectively used supporting clinical data.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #274 – fractures, Individual #256 – choking, Individual #416 – GI problems, and Individual #331 – weight.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: Denton SSLC made excellent progress in developing psychiatry related goals for individuals and in identifying psychiatric indicators. This is evident in the detail in the comments below. Next steps are to make sure there is consistency in the goals across the psychiatric documents and to work on obtaining reliable data on the psychiatric indicators. Even so, the various goals that were in the various documents were based upon assessment and related to the psychiatric diagnosis for most of the individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

		0/9									
6	The goals/objectives are based upon the individual's assessment.	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
The Denton SSLC psychiatry department had begun to identify psychiatric indicators for individuals. This will allow them to begin to develop goals based on these indicators. This outcome contains four indicators that each addresses an important aspect of the goals. Each will be discussed in turn below.

A number of years ago, the State proposed terminology to help avoid confusion between psychiatric treatment and behavioral health services treatment, though the two disciplines must work together in order for individuals to receive comprehensive and integrated clinical services, and to increase the likelihood of improvement in psychiatric condition and behavioral functioning.

In behavioral health services positive behavior support plans (PBSPs), the focus is upon what are called target behaviors and replacement behaviors. These are the observable, measurable behaviors for reduction and for increase, respectively. They are hypothesized to be, for the most part, under operant control. A functional assessment is conducted to determine the variables that set the occasion for, and maintain, target behaviors (i.e., their function). Replacement behaviors are chosen to provide a functionally equivalent, more socially appropriate alternative to the target behavior. Replacement behaviors sometimes need to be taught to the individual. Many times, however, replacement behaviors are already in the individual's repertoire, in which case the task for the Center is to set the occasion for those replacement behaviors to occur, be reinforced, and maintained.

In psychiatry, the focus is upon what have come to be called psychiatric indicators. These are the observable, measurable symptoms chosen by the psychiatrist (with input from behavioral health services and IDT members) to determine the presence, level, and severity of the individual's psychiatric disorder. They are hypothesized to be, for the most part, due to the individual's psychiatric disorder. Psychiatric indicators can be psychometrically sound rating scales, and/or data collection recordings of symptoms directly observed by SSLC staff. Psychiatric indicators need to be directly related to (derived from) the individual's diagnosis or diagnoses. Individuals should have psychiatric indicators (and goals) that are related to the reduction of psychiatric symptoms and goals/objectives related to the increase of positive/desirable behaviors. Sometimes, a PBSP target behavior can also serve as a psychiatric indicator, though usually, psychiatric indicators will not be solely PBSP target behaviors.

Goals for behavioral health services typically appear in the functional assessment and/or the PBSP. Goals for psychiatry typically appear in the annual psychiatry update and/or quarterly psychiatry clinic review reports. Goals for behavioral health services and for psychiatry ultimately need to appear in the behavioral health risk section of the IHCP.

4-5. The Monitoring Team, below, provides a summary of what could be gleaned from the various ISP and psychiatry documents regarding psychiatry goals and psychiatric indicators. As is evident from the below, much progress has been made. To meet criteria with indicators 4 and 5, the goals need to include criterion (amount of psychiatric symptoms, and over a specified time period), contain (or reference) operational observable definitions of psychiatric indicators, and appear in the IHCP. There needs to be at least one goal regarding psychiatric indicators for decrease and one regarding psychiatric indicators for increase (i.e., a goal is not necessary for every diagnosis).

In general, most individuals had goals. Also, in general, there was not consistency in the goals that were presented in the IRRF, in the IHCP, and in psychiatry's various documents (e.g., annual CPE, quarterly clinics, interim reviews). Goals of course can change over the year, but the Monitoring Team did not see how or when goals were updated.

At Denton SSLC, parts of these requirements were evident at different stages for all individuals.

- Individual #96: This individual's set of goals was the best of those in the review group. There was a goal to decrease self-injurious behavior to two or fewer instances per month for six months, that suicide gestures and suicide threats will maintain at zero instances per month, and that appropriate refusals will occur 30 or more times per months. In addition, there were goals to decrease mood lability, impulsivity, irritability, and insomnia. There was also a goal for a positive indicator, which was to maintain current stability at his work program. Finally, there was a goal regarding avoiding medication side effects.
- Individual #115: Per the ISP, there were no behavioral health goals established and there were none in the IHCP. Even so, there was a psychiatric indicator noted, which was aggression/crying. But in other sections of the same psychiatric documentation, there was another psychiatric indicator regarding voicing suicidal thoughts or taking actions to harm herself, as well as positive indicators, such as using coping skills.
- Individual #227: There were goals in the ISP that she will be free of medication side effects, maintain current psychiatric stability, decrease aggressive behavior, and increase the replacement behavior of appropriate requesting. Aggressive behavior and appropriate requesting were target/replacement behaviors from her PBSP. There was no definition of psychiatric stability. In the goals grid in the psychiatric documents, aggressive behavior and acute mood symptoms were listed.
- Individual #157: The goals included in the IHCP were regarding reducing PBSP target behaviors, increasing the PBSP replacement behavior, and monitoring for medication side effects. There were no psychiatric goals or indicators identified.
- Individual #159: In the ISP, there was a goal to reduce or stabilize psychiatric indicators in the next year, but there was no description or definition of what those indicators were. In the IRRF, there was a psychiatric goal to decrease aggression and to increase replacement coping skills associated with a diagnosis of IED.
- Individual #173: In the ISP, the behavioral health goals were to reduce targeted behaviors in the next year, increase replacement behaviors in the next year, reduce or stabilize psychiatric indicators in the next year, and reduce or eliminate restraints in the next year. But in the goals grid in the psychiatric documents, the

goals were to reduce depressive symptoms and impulsive aggressive behaviors, and to increase replacement behaviors/appropriate refusals. These were not written as measurable, only that they should decrease and increase, respectively.

- Individual #274: In the IHCP, there were broadly worded goals to monitor for medication side effects and to decrease target behaviors and increase replacement behaviors. The psychiatric documents grid, however, included changes in mood, irritability, or agitation; reporting feeling sad or hopeless or appearing depressed; self-injury; changes in eating or sleeping patterns; and hyperactivity. But then in another section, there was documentation of a psychiatric goal for crying.
- Individual #543: In the ISP, there was a goal to remain free of medication side effects and to have no episodes of physical aggression toward others for one year. The IRRF had psychiatric indicators regarding stereotypies, aggression, and irritability. There were no psychiatry related goals included in the IHCP. The goals grid in the psychiatry documents indicated maintaining activities, reducing aggression, maintaining stability with temper tantrums, and maintaining stability in taking walks and helping in the cafeteria.
- Individual #25: The psychiatric goals in the IRRF were about hyperactivity, impulsivity, restless, and insomnia, plus a prosocial goal of improving social and communication skills. The IHCP had goals regarding monitoring for medication side effects and reducing targeted behaviors in the next year.

6. Goals (and their psychiatric indicators) must be related to the individual's assessment and diagnosis.
   - The Monitoring Team does not require that there be a separate goal for reduction and a separate goal for increase for every diagnosis.
   - The Monitoring Team looked at the entire set of goals for each individual and, as a result, seven individuals were scored 1. These individuals had psychiatric indicators identified that related to their psychiatric diagnosis. In the case of Individual #115, it was difficult to determine what the indicators were because there were different indicators documented in the psychiatric clinical quarterlies (e.g., designated as indicators in one section, but different from those included in the goals grid). In the case of Individual #274, there were no indicators related to the diagnosis of Intermittent Explosive Disorder.
   - For individuals with autism, a psychiatric indicator for treatment with medications could be irritability. In these cases, it is fine for aggression to be an additional psychiatric indicator (it already was a target behavior in the PBSP).

7. Reliable and valid data need to be available so that the data can be used by the psychiatrist to make treatment decisions. Often, the data are presented in graphic or tabular format for the psychiatrist. Data need to be shown to be reliable. Reliability assessments are often done by behavioral health services, residential, or psychiatry staff. In addition to using data on psychiatry goals/indicators, psychiatrists often utilize behavioral health services target/replacement behavior data when making treatment decisions.
   - Reliable data were not reported for behavioral health services target and replacement behaviors for individuals who were seen by psychiatry.
   - There was no system to adequately collect or assess the reliability of the data on psychiatric indicators (that were not also target behaviors in the PBSP).

- For example, regarding Individual #25, there were problems with the reliability/accuracy of medication dosage changes and their relationship to other data points. This is an especially important piece of data for psychiatrists and should be one of the easier pieces of data to collect.

- Ensuring reliable data is an area of focus for the psychiatry department. Likely, accomplishing this will require collaborative work between psychiatry, behavioral health, residential services, day/vocational services, and the Center's ADOP.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: All individuals had a CPE and it contained all of the Appendix B sections. This was the case for the past three reviews, too (with some exceptions in September 2016). Therefore, indicator 13 will be moved to the category of requiring less oversight. The other two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	227	96	157	159	173	274	543	25
12	The individual has a CPE.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
14	CPE content is comprehensive.	33% 3/9	0/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1
15	If admitted within two years prior to the onsite review, and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	67% 6/9	1/1	1/1	1/1	0/1	0/1	1/1	0/1	1/1	1/1

Comments:

13. All individuals who required an initial CPE had one and it had the required format/sections.

14. The Monitoring Team looks for 14 components in the CPE. The evaluations regarding Individual #25, Individual #173, and Individual #227 met all the requirements. Four of the other evaluations lacked a sufficient bio-psycho-social formulation. This was the most common deficiency. Three evaluations were lacking sufficient

information in one element and three evaluations were lacking sufficient information in three elements.

16. There were two individuals whose documentation revealed inconsistent diagnoses: Individual #159 and Individual #274. A third individual's, (Individual #157) behavioral health assessment was outdated, it was dated 11/29/16, and therefore, a 0 was scored for this element.

Outcome 5 – Individuals' status and treatment are reviewed annually.

Summary: Annual updates were completed for all individuals, though most were missing one or more components, usually demographic information. The updates were completed and submitted to the IDT in a timely manner and with sustained high performance, this indicator (19) might be moved to the category of requiring less oversight after the next review. The final ISP document did not contain all of the required content, however, for one individual (Individual #227) the ISP documentation was thorough and met criteria. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	227	96	157	159	173	274	543	25
17	Status and treatment document was updated within past 12 months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	25% 2/8	1/1	N/A	0/1	0/1	0/1	0/1	1/1	0/1	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	11% 1/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
18-19. The Monitoring Team scores 16 aspects of the annual evaluation document. Eight individuals required annual evaluations. All were completed. Two annual evaluations, regarding Individual #274 and Individual #115 contained all of the required elements. The other six evaluations were missing elements. The most common deficiency was regarding demographic information. Five evaluations were missing this element. One evaluation was missing four elements. The Monitoring Team scored indicator 19 based upon completion of either the annual

evaluation or a quarterly review within 90 days of the ISP meeting.

21. There was a need for improvement with regard to the documentation of the ISP discussion to include the rationale for determining that the proposed psychiatric treatment represented the least intrusive and most positive interventions, the integration of behavioral and psychiatric approaches, the signs and symptoms monitored to ensure that the interventions are effective and the incorporation of data into the discussion that would support the conclusions of these discussions, and a discussion of both the potential and realized side effects of the medication in addition to the benefits.

When reviewing the IRRFs for the individuals, seven had adequate documentation of a discussion of both the potential and realized side effects of the medication, in addition to the benefits. This was good to see. With regard to the other required elements, there were statements regarding the least intrusive interventions and integration, but what was missing was the rationale.

The IRRF documentation regarding Individual #227 was scored as 1 because there was a discussion of medication side effects and realized side effects. There was discussion of the symptoms that would be monitored. Data were not included in the IRRF because this was a new admission. There was significant historical information included in the IRRF regarding the current treatment being the least intrusive. As for the integration of approaches, as Individual #227 is a new admission, there will need to be time for this integration to develop.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.

Summary: Two PSPs were reviewed. Some aspects of each were not in place and/or the PSP was not updated. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	227	96	157	159	173	274	543	25
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
22. None of the individuals in the review group had a PSP, so PSP documents for Individual #790 and Individual #765 were reviewed. The PSP for Individual #790 was out of date because it was implemented 2/1/17 and, therefore, was scored 0. The PSP for Individual #765 did not include a purpose. There were psychiatric indicators listed, and the document stated that the symptom ratings would be collected and recorded manually, but it was not clear what would be rated or how.

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.

Summary: Signed consent forms with understandable content and HRC review continued at 100% performance for this and the two previous reviews, too. Therefore, indicators 28, 29, and 32 will be moved to the category of requiring less oversight. The risk benefit discussion improved to its highest scoring yet (indicator 30). The referencing of alternate and/or non-pharmacological interventions needs to be included (indicator 31). These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
32	HRC review was obtained prior to implementation and annually.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

29. The consent forms included some medication side effect information. The facility provided medication information sheets with the consent forms for complete side effect information.

30. The risk versus benefit discussion was included in the consent forms via a series of check boxes. In eight cases, there was additional individualized information included.

31. The consent forms did not include individualized alternate and non-pharmacological interventions. There were alternative interventions included on the form, but these were not individualized.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: Individuals who needed a PBSP had one, however, the Monitoring Team provided some comments below regarding three individuals for whom further assessment of their plans (or need for a plan) should be done (indicator 1). All individuals had goals (with the exception of goals in counseling for Individual #115, a new admission). All of the goals were written in measurable terminology (indicator 3) and were based upon assessments. This was the case for the former for the last three reviews with an exception in the last two reviews. Therefore, indicator 3 will be moved to the category of requiring less oversight. With sustained high performance, indicator 4 might also be moved to this category after the next review. The obtaining/collection of reliable data for these goals, however, remained a challenge and problem for Denton SSLC. This pivotal activity requires attention from the behavioral health services department. This indicator (5) will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.										
3	The psychological/behavioral goals/objectives are measurable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	the individual's status and progress.	0/9									

Comments:

1. Although this indicator was, and will remain, in less oversight. The Monitoring Team has comments regarding three individuals.

- It was reported that Individual #669 experienced frequent falls. One of the recommendations following a Root Cause Analysis was for staff to collect data on controlled versus uncontrolled falls. While it was evident that this data collection had been initiated, there were problems regarding the assessment of this behavior. Her FBA had been completed prior to the RCA and there was no indication that additional observations were conducted by the BHS. This is recommended particularly because staff were reporting that she loses her balance and does not deliberately engage in this behavior. After this, the IDT should determine whether intervention guidelines should be added to her PBSP.
- Similarly, Individual #327 had moving to the floor identified in his PBSP. When his FBA was completed, the behavioral health services specialist observed no targeted problem behaviors. Again, additional observations are recommended.
- The Monitoring Team observed Individual #449 screaming and repeatedly hitting himself in the head. He had neither a PBSP nor a PSP. Staff are advised to complete a functional behavior assessment to determine whether a PBSP is warranted.

3-4. The identified goals/objectives for all nine individuals were measurable and based upon assessments.

5. Reliable and valid data were not available to assess individual progress or the lack thereof. Inter-observer agreement was not assessed regularly per facility policy and timely recording of data remained a problem. Individual specific problems were also observed during the onsite visit.

- Although a paper data sheet had been developed for Individual #173 due to the high rates of problem behavior and his required level of supervision, during two observations the data sheet was not available. When the staff member was asked about this during Individual #173's Life Skills program in the gym, he explained that the data sheet was back at the house.
- At Individual #25's psychiatric clinic, there were multiple problems noted with his data. His QIDP reviewed occurrences of stripping and at least one occurrence of self-injury in February 2018. The table presented in the most recent PBSP progress note indicated that neither of these behaviors had occurred. Further, when a question was asked about running, indicated as a high frequency behavior in most of his assessments/reports, the behavioral health specialist stated that CareTracker did not have a widget for recording running. As a result, this behavior was included under attempted unauthorized departure (AUAD). When asked how one could assess one behavior versus another, the specialist indicated that if he displayed AUAD, he would have been restrained. The table reflected no occurrences of restraint since March 2017, but this did not match the master list of crisis restraints (one restraint each in October 2017 and November 2017). The graphs depicting all targeted problem behaviors suggested that running had not occurred over the past 12 months.
- Additionally, during the onsite visit, three individuals were observed engaging in one of their targeted

problem behaviors. A check of raw data sheets indicated that documentation was completed for one of these individuals.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.

Summary: Performance was about the same as at the last review for indicators 10 and 11 and lower for indicator 12. Behavioral assessments continued to be incomplete or not current or updated. Not all functional assessments were current or updated or complete. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	227	96	157	159	173	274	543	25
10	The individual has a current, and complete annual behavioral health update.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
11	The functional assessment is current (within the past 12 months).	78% 7/9	1/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1
12	The functional assessment is complete.	56% 5/9	0/1	0/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1

Comments:

10. The facility provided documents labeled Integrated Behavior Health Assessment. For five individuals, the assessment was determined to be current at the time of the document request based upon the date indicated on the first page. Exceptions were Individual #157, Individual #96, Individual #159, and Individual #173.

None of the assessments included a review of the individual's physical health from the previous year. Although alternative assessments of adaptive behavior were included, the I-CAP was either missing (Individual #157) or overdue (Individual #173, Individual #25).

11. Seven of the nine individuals had a current functional behavior assessment. The exceptions were Individual #157 and Individual #173 whose assessments were completed in January 2017 or were not dated, respectively. Updated assessments (done in March 2018) were requested and provided while the Monitoring Team was onsite.

12. The FBA was considered complete for five individuals, Individual #96, Individual #157, Individual #173, Individual #274, and Individual #25. Although direct observations were completed for Individual #115, Individual #227, Individual #159, and Individual #543, not all target behaviors were observed. There was no statement as to why additional observations were not necessary.

Staff are advised to record the dates the assessments (both direct and indirect) are completed because without these, it is difficult to determine whether the information is current. For example, the FBA for Individual #543

noted that family and staff were interviewed, but there was no information as to when this occurred. Further, it was reported that he had been observed in a variety of settings at a variety of times in April 2017, but specific information was not provided. Individual #543's report also indicated there were times when he may become agitated after staff have refused his access to the bathroom by telling him to wait.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.

Summary: Almost all PBSPs were implemented timely. With sustained high performance, this indicator (13) might be moved to the category of requiring less oversight after the next review. There also was improvement in the PBSPs being current for almost all individuals. There was improvement in the content of PBSPs, but even so, important components were missing from every one of them. Detailed comments are provided below in indicator 15. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
14	The PBSP was current (within the past 12 months).	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

13. Based upon the consent tracking information provided by the facility, eight of the nine PBSPs were implemented within 14 business days of all consents. The exception was Individual #543 whose PBSP was implemented more than 14 days after the last consent.

14. The PBSPs for eight of the nine individuals were current. The exception was Individual #157, whose PBSP was implemented in February 2017. When an updated assessment and PBSP was requested onsite, this was provided (March 2018).

15. Although none of the PBSPs were considered complete, several indicators were met in six or more of the plans. These included operational definitions of targeted problem behaviors and functionally equivalent replacement behaviors, consequent strategies, and treatment objectives.

Elements that were missing included the use of positive reinforcement in a manner likely to affect behavior change and sufficient opportunity for replacement behavior to be reinforced.

Individual specific feedback is provided below.

- In Individual #115's plan, property destruction and SIB were defined as episodes separated by one minute without occurrence, and her replacement/ alternative behaviors were measured using a one-hour partial interval count. Staff are advised to ensure that graphs are labeled accordingly. Similarly, aggression and verbal disruption displayed by Individual #274 were graphed as episodes although the PBSP contained operational definitions of occurrences.
- Staff are advised to check the written descriptions of suicidal threats versus suicidal gestures. In the plans for Individual #115, Individual #227, and Individual #159 these definitions were reversed.
- Antecedent or prevention strategies were not always comprehensive. Examples included the following: Individual #96 was to set goals for the day/week/month, but the type of goals were not specified; Individual #157 was to be reminded of the next scheduled cigarette, after which staff should "prepare to have increased challenging behaviors;" Individual #159's plan identified several triggers, but no guidelines were provided to address these; and one important element reported by all staff who worked with Individual #543 was his having access to his favorite chair in both the home and day program - this was not addressed in the prevention section.
- Staff are once again advised to delete the use of the term "junk" behavior from their lexicon. This is a pejorative term that shows a lack of respect for the individual, particularly as the behavior likely serves a purpose. If the individual displays unwanted behaviors that are not specifically targeted in his or her plan, these should be identified and operationally defined so that staff can consistently "pivot" when they occur.

BARC: During the onsite visit, the Monitoring Team met with the director of the Behavior Analysis Resource Center and Individual #173's BCBA. A brief history was provided and the fading plan for the use of a protective mechanical restraint (arm splints) for self-injurious behavior was reviewed. Several suggestions were discussed during this meeting. These and additional recommendations are outlined below.

- The PBSP targeted three forms of self-injury, but not his banging his hands/arms against objects. This was concerning for several reasons. First, he fractured his hand and it could not be ruled out that he did this by engaging in this behavior. Second, when he was observed completing his SAP, he displayed this behavior repeatedly. Third, his QIDP reported that the team stopped tracking this behavior because it occurred too frequently. As discussed, even if data could be collected during identified times of the day, this would be helpful in assessing the frequency and providing staff guidelines for addressing the behavior.
- The BCBA reported that Individual #173 will display behaviors prior to engaging in disruptive behavior. If these precursors could be operationally defined, staff instructions could be provided for intervening earlier in the chain.
- It would be helpful for a speech therapist to complete an assessment for a possible augmentative communication system (e.g., the Picture Exchange Communication System, use of an iPad).
- A sensory assessment should be completed, particularly because automatic reinforcement was identified as

a possible function for at least two of his targeted problem behaviors.

- Individual #173 had a very limited range of activities in which he participated. Therefore, assessment of his preferences should occur regularly.
- The fading plan did not clearly outline the steps involved. It noted that one or both splints may be removed and did not outline how the time out of splints will be increased. Currently, only one session was conducted on designated days. Review of data between 9/1/17 and 1/31/18 indicated that 36 fading sessions occurred, with 12 of these sessions exceeding two minutes. It was suggested to increase the frequency of fading sessions and possibly making these time-based. If the latter is implemented, it would be advisable to use a visual timer to help Individual #173 understand when the splints will be re-applied.
- The plan noted that circulation checks should be done every 30 minutes. It was not clear who was responsible for completing these checks, nor was there any documentation to indicate that these had been done. If direct support professionals are responsible, there should be directions for completing the checks. Skin integrity checks should also occur regularly with ongoing documentation.
- It would be helpful to have documentation on his food and fluid intake.
- It was reported that the QIDP had made the decision to put on new splints at the start of every day. This would allow for washing one pair while another pair was worn. Because the splints may not dry in one day, it would be advisable to have multiple pairs on his home.
- The BCBA described language that Individual #173's mother used and avoided using when removing his splints. It would be advisable to include this in the fading plan, so that this information is not lost over time.
- Treatment integrity was not being assessed on a regular basis. Over a six-month period, there was evidence that this had occurred twice. Individual #173's PBSP and PMR-SIB were complex plans, so it is essential that treatment integrity be assessed frequently.
- During two observations of his day program, Individual #173's paper data sheet was not in evidence. During one of these observations, when the staff was asked about the sheet, he responded that it was back at Individual #173's home.

ISPAs indicated multiple restrictions discussed for several individuals. Examples included Individual #227 not being allowed to take her book bag to work, and Individual #274 having his television and video games controllers removed from his room and restricting him from his home if he didn't go to work. It was not always clear whether these had been approved by the Human Rights Committee. IDTs are advised to hold subsequent ISPA meetings to review the status of these restrictions.

Four of the nine individuals (Individual #115, Individual #96, Individual #159, Individual #25) had a Crisis Intervention Plan. The plan for Individual #96 was dated and signed; the others were not dated and signed. There was no evidence that the other CIPs had been reviewed and approved by the individual's guardian and the Human Rights Committee.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.

Summary: Attention needs to be paid to ensure that actions are taken to support individuals to receive counseling services if that is what the IDT has proposed (as had been the case in the past at Denton SSLC). For three individuals, counseling was delayed or modified with no rationale. The Monitoring Team will leave indicator 24 in the category of requiring less oversight, however, performance needs to improve or it is possible that it may be returned to active monitoring after the next review. Indicator 25 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	0% 0/2	0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 25. The counseling plan for Individual #96 was dated October 2017, but was not signed until March 2018. Although it included objectives, it will be necessary for the counselor to operationalize the expected behaviors. It was not clear what evidence-based approach was being utilized, nor did the plan include criteria for terminating counseling services.											

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Center staff should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. Indicator c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	Due to the Center's sustained performance, these indicators were moved to the category requiring less oversight.									

b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.										
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: c. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." Interval reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interval reviews will need to occur more frequently. The IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Center staff should continue to improve the quality of the medical assessments. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	Individual receives quality AMA.	56% 5/9	1/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance, this indicator was moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. It was positive that five individuals' AMAs included all of the necessary components, and addressed individuals' medical needs with thorough plans of care. Problems varied across the remaining medical assessments the Monitoring Team reviewed.

- It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed childhood illnesses, social/smoking histories, past medical histories, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, pertinent laboratory information, and updated active problem lists.
- Most, but not all included pre-natal histories, and family history.
- Moving forward, the Medical Department should focus on ensuring medical assessments include plans of care for each active medical problem, when appropriate. Some of the PCPs appeared to have a narrow

focus when defining the medical or healthcare needs of the individual, and this needs to be broadened. For instance, PCPs were unaware of individuals' frequent falls. Even falls without injury are significant, and could be indicative of an underlying medical issue, which would need to be addressed in the AMA.

c. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #157 – fluid imbalance, and weight; Individual #274 – cardiac disease, and weight; Individual #669 – circulatory, and falls; Individual #86 – respiratory compromise, and gastrointestinal (GI) problems; Individual #327 – seizures, and falls; Individual #256 – GI problems, and constipation/bowel obstruction; Individual #435 – urinary tract infections (UTIs), and respiratory compromise; Individual #416 – GI problems, and constipation/bowel obstruction; and Individual #331 – diabetes, and skin integrity].

As noted above, the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.

Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs. These indicators will continue in active oversight.

Individuals:

#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #157 – fluid imbalance, and weight; Individual #274 – cardiac disease, and weight; Individual #669 – circulatory, and falls; Individual #86 – respiratory compromise, and GI problems; Individual #327 – seizures, and falls; Individual #256 – GI problems, and constipation/ bowel obstruction; Individual #435 – UTIs, and respiratory compromise; Individual #416 – GI problems, and constipation/bowel obstruction; and Individual #331 – diabetes, and skin integrity). None of the ISPs/IHCPs included a full set of medical action steps to address individuals' chronic or at-risk conditions.

b. As noted above, the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current

standards of practice, and accepted clinical pathways/guidelines.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: Over this review and the last one, improvement was noted with regard to the timely completion of annual dental exams and summaries. If the Center sustains this progress, at the time of the next review, Indicators a.ii and a.iii might move to the category requiring less oversight. Good progress was noted, and the Center should continue its focus on improving the quality of dental exams and summaries. At this time, all of these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A									
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	56% 5/9	1/1	0/1	1/1	0/1	1/1	0/1	0/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: a. and b. For all nine individuals reviewed, the Dentist completed timely annual dental exams and annual dental summaries, which was good to see. b. It was positive that for five of the nine individuals reviewed, the dental exams included all of the required											

components. It was also good to see that all of the remaining dental exams reviewed included the following:

- A description of the individual's cooperation;
- An oral hygiene rating completed prior to treatment;
- Periodontal condition/type;
- The recall frequency;
- Caries risk;
- Periodontal risk;
- An oral cancer screening;
- Information regarding last x-ray(s) and type of x-ray, including the date;
- Treatment provided/completed;
- An odontogram;
- A treatment plan; and
- Periodontal charting.

Most, but not all included:

- Sedation use.

Moving forward, the Center should focus on ensuring dental exams include, as applicable:

- A summary of the number of teeth present/missing.

c. It was very good to see that all of the dental summaries reviewed included the following:

- Effectiveness of pre-treatment sedation;
- Recommendation of need for desensitization or another plan;
- A description of the treatment provided (i.e., treatment completed);
- The number of teeth present/missing;
- Dental care recommendations;
- Dental conditions that could cause systemic health issues or are caused by systemic health issues;
- Treatment plan, including the recall frequency;
- Provision of written oral hygiene instructions; and
- Recommendations for the risk level for the IRRF.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.	
Summary: Full physical assessments were not documented for a number of individuals (i.e., missing were fall assessments, weight graphs, and Braden scores, as well as reviews of risk areas). In	Individuals:

addition, nurses did not include status updates in annual assessments, including relevant clinical data. As a result, nurses had not analyzed this information, including comparisons with the previous quarter or year. The Center should focus on ensuring nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice. All of these indicators will remain in active oversight.											
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	22% 2/9	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	8% 1/12	0/2	1/1	0/2	0/1	0/2	0/1	0/1	0/1	0/1
Comments: a. Full physical assessments were not documented for a number of individuals, including, for example, weight graphs, fall assessments, and/or Braden scores. In addition, many annual and quarterly reviews did not provide a comprehensive review and summary of each risk area. b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e.,											

Individual #157 – weight, and skin integrity; Individual #274 – fractures, and GI problems; Individual #669 – falls, and constipation/bowel obstruction; Individual #86 – UTIs, and skin integrity; Individual #327 – falls, and other: osteoarthritis; Individual #256 – choking, and constipation/bowel obstruction; Individual #435 – skin integrity, and UTIs; Individual #416 – constipation/bowel obstructions, and GI problems; and Individual #331 – falls, and weight).

Overall, none of the annual comprehensive nursing assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. However, for one of the risk areas reviewed, the nurse included status updates, including relevant clinical data (i.e., Individual #331 - falls). Unfortunately, the nurse did not analyze this information, including comparisons with the previous quarter or year, and/or make recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

c. The following provide a few of examples related to nursing assessments in accordance with nursing protocols or current standards of practice in relation to individuals' changes of status:

- On a positive note, on 1/25/18, for Individual #274, the nurse described an assessment related to emesis that was consistent with current nursing guidelines/standards.
- In December 2016, Individual #157 weighed 144.6 pounds, but in August 2017, he weighed 127.3 pounds. After this substantial weight loss, he gained significant weight, and in March 2018, reached 142 pounds. During his period, he refused meals, was on a fluid restriction due to elevated sodium levels, and had episodes of high blood pressure. Nursing staff did not initiate nursing assessments.
- A nursing IPN, dated 1/20/18, noted that Individual #157 had a rash/hives. The nurse did not include the temperature of the individual's skin; whether or not there was any drainage; a description of the areas including if they were fluid-filled, or if there were scabbed areas; whether there was an odor; if the rash/hives were concentrated in a certain area; and/or assessment of the individual's scalp and mouth mucosa.
- According to a Post-Injury Form, dated 8/6/17, staff found Individual #669 on the floor in her room on her left side screaming for help to get up. The nursing IPN, dated 8/6/17, regarding follow-up for this fall only noted the following: "Individual alert sitting on couch, no distress noted. No bruises noted from post injury." The nurse conducted and/or documented no assessment of mental status, gait, skin, ability to perform activities, or pain scale from the individual's perspective.

  Also, of concern, during the onsite review, the medication nurse indicated that Individual #669 was experiencing tremors/hand shaking. When the Monitoring Team requested documentation, the Center indicated that no documentation was found to show that nursing staff had documented this observation and/or made her IDT aware of this new symptom.
- On 1/15/18, nursing staff administered Individual #669 a pro re nata (PRN or "as needed") medication for constipation. However, no corresponding IPN showing a nursing assessment for constipation was found in the submitted documentation. Similar concerns were noted for Individual #416 on 1/23/18, and Individual

#256 on 8/18/18.

- According to a PCP IPN, dated 9/15/17, Individual #86 was diagnosed with a UTI with E. coli and began a course of antibiotics. Nurses did not mention the UTI in nursing IPNs until 9/18/17, and nurses made no mention of the organism related to the UTI or the need to train staff regarding hygiene and ensure catheterizations were done under sterile conditions to avoid contamination.
- An IPN, dated 1/11/18, indicated that Individual #327 fell in the morning and came back from the workshop pointing to his right side. The nurse noted that he had a bruise on his right side measuring 10 by 4 centimeters (cm). However, the nurse did not conduct and/or document an assessment of swelling, skin temperature, gait, range of motion, pain, or assessment of other areas of the body for additional bruises.
- For Individual #435, an IPN, dated 8/3/17, noted slight redness to the bilateral labia and groin. The nurse did not indicate whether or not other areas of her skin were assessed or that the PCP was notified.
- On 1/9/18, Individual #331 fell. No IPN was found to show that a nurse assessed him.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.

Summary: Given that over the last several review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	6% 1/18	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0/18									
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: b. Individual #256's IHCP for constipation/bowel obstruction contained an action step for ongoing nursing assessment. It required nurses to evaluate his abdomen for distension, tenderness, and bowel motility. This was a step in the right direction. However, the action step did not include assessment of bowel sounds, and it was unclear how nurses would measure "bowel motility." In addition, the IHCP did not define the frequency of such assessments.											

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.											
Summary: It was positive that as needed, a Registered Nurse (RN) Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results. If the Center sustains its progress in this regard, at the time of the next review, Indicator e might move to the category of less oversight. Although IDTs continued to improve with regard to referring individuals to the PNMT, when needed, this is an area that requires continued focus. Of concern, a number of individuals who should have had comprehensive PNMT assessments did not. The Center also should focus on the quality of the PNMT comprehensive assessments. At this time, all of these indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	75% 6/8	1/1	1/1	1/1	1/1	0/1	N/A	1/1	1/1	0/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	75% 6/8	1/1	1/1	1/1	1/1	0/1		1/1	1/1	0/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	17% 1/6	N/A	0/1	0/1	0/1	N/A		0/1	1/1	0/1

d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	25% 2/8	1/1	0/1	0/1	0/1	0/1		0/1	1/1	0/1
e. y	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 4/4	N/A	N/A	N/A	1/1	N/A		1/1	1/1	1/1
f. y	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/8	0/1	0/1	0/1	0/1	0/1		0/1	0/1	0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/3	0/1	N/A	N/A	N/A	0/1		N/A	0/1	N/A
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/6	N/A	0/1	0/1	0/1	N/A		0/1	0/1	0/1

Comments: a. through c., and f. and g. For the eight individuals that should have been referred to and/or reviewed by the PNMT:

- Individual #157's weight decreased over the course of nine months (December 2016 to September 2017) from 145 pounds to 123.2 pounds. Although on 9/8/17, the PNMT responded to the referral the IDT made on 9/6/17, in a timely manner, the referral was delayed in that the individual already lost a significant amount of weight. The PNMT review contained the presenting problem and indicated the "root cause" of weight loss was meal refusals. The individual expressed that the food at the Center was "awful," hence the refusals. The review focused only on weight loss and did not describe PNMT member observations of the individual to determine whether or not any other areas were impacted. For example, it would have been essential for the PNMT to determine if he had problems at mealtime (e.g., with swallowing) that impacted his intake. In addition, it would have been important for the PNMT to determine whether or not the weight loss impacted the fit of his ankle-foot orthosis (AFO), or the fit of clothing, which could increase the risk of falls. It also would have been important to determine if the weight loss impacted his stamina, again increasing his fall risk.
- Over the 18 months prior to the Monitoring Team's review, Individual #274 had multiple PNM issues. More

specifically, the PNMT reviewed him for a fall that resulted in a fracture on 6/10/17, but did not conduct a thorough enough review to determine the impact of the individual's behaviors on the fall. The PNMT review recommended following the IDT's plan, but the IDT's plan did not address the behavioral implications. Then, in September 2017, the PNMT conducted another review focused on emesis. At the conclusion of the review, the PNMT recommended discharge, because the action plans in place were "effective," despite the fact that Individual #274 was still having emesis. On 11/2/17, the PNMT conducted another review due to the same emesis issues, and then, in January 2018, the IDT again made a referral to address the individual's overweight status. More specifically, since his admission in August 2016, he gained approximately 50.5 pounds, with a weight-gain of 29 pounds occurring between January 2017 and January 2018. The PNMT should have, but did not, conduct a comprehensive assessment to assess the relationships between falls and behaviors, between weight and emesis, as well as between behavior and weight.

- In August 2017 and again in September 2017, the PNMT conducted reviews of Individual #669 for falls. Since September 2017, she fell nine more times with no additional PNMT participation. Both reviews concluded that the falls could be behavioral, and/or that it was difficult to determine if falls were actual falls or the individual sitting down. The PNMT did not work with the IDT to ensure that additional data were collected or that a clear behavioral plan was put in place to address the issues. Given that the action plans the PNMT developed during the first two reviews were not effective, more PNMT involvement was warranted, including the completion of a comprehensive assessment. The August 2017 review listed a BCBA on the list of participants, but did not include a signature. The second fall review did not list the BCBA, but both reviews stated that Individual #669's falls were likely behavioral in nature.
- Due to the ongoing nature of Individual #86's PNM-related issues beginning in June and continuing through November (i.e., pneumonia on 5/21/17, respiratory distress on 6/9/17, aspiration pneumonia with a tracheostomy placement on 9/18/17, and respiratory distress on 10/1/17), a comprehensive assessment was warranted. During multiple reviews, the PNMT mentioned the need for Habilitation Therapy staff to assess the individual's head-of-bed elevation (HOBE), but the Center did not submit evidence that this occurred. This same recommendation was present in the 6/13/17 PNMT review, the 6/26/17 PNMT note, the 10/13/17 review, and the 10/17/17 review. If the PNMT had completed a comprehensive assessment, it could have addressed the head-of-bed elevation evaluation within that document. Reviews also lacked identification of the etiology or "root cause" of the individual's PNM issues. For example, the PNMT stated the individual's aspiration pneumonia was due to thickening secretions, but did not address adequately the cause of the thick secretions. The same issue was noted with regard to emesis. The PNMT stated a urinary tract infection (UTI) caused emesis, and emesis caused aspiration pneumonia, but the PNMT did not provide the data to support these conclusions.
- Since October 2017, Individual #327 fell at least nine times. The falls were an ongoing issue that continued despite receipt of direct PT therapy to address falls. Based on the documentation provided, the IDT did not refer the individual to the PNMT, and the PNMT did not conduct a review.
- Between March 2017 and her death in December 2017, Individual #435 had multiple issues, including hospitalizations for pneumonia from 2/28/17 to 3/17/17, again from 3/18/17 to 3/23/17, chronic respiratory

failure from 3/24/17 to 3/30/17, trouble breathing on 6/22/17, respiratory distress on 9/5/17, and low oxygen saturation levels on 9/14/17. Additionally, on 3/31/17, undesired weight gain was noted. The PNMT conducted a review of her weight and then another review on pneumonia. Due to the multiple issues, such as weight gain and pneumonia, and the impact these events had on her whole body, a comprehensive assessment was warranted. The reviews did not reflect that the PNMT conducted any actual assessment, and the PNMT proposed "root causes" and stated these were "based on data," but the PNMT provided no data to support its determinations.

- On 11/16/17, Individual #416's IDT referred him to the PNMT for aspiration pneumonia. The PNMT conducted a timely review, and on 11/17/17, initiated a comprehensive assessment, which was completed on 12/6/17. The quality of the assessment is discussed below. On 1/28/18 to 2/5/18, the individual was hospitalized with the diagnosis of the flu and low oxygen saturations. Although the PNMT conducted a review, the documentation described no specific observations that PNMT members made to determine whether or not the hospitalization had impacted Individual #416's overall functioning.
- On 8/21/17, Individual #331 experienced altered respiratory status. On 9/3/17, he had low oxygen saturation levels, and again, in 10/21/17, he had pneumonia, with no evidence of PNMT discussion. The first PNMT review regarding pneumonia was not completed until 12/11/17, in response to a diagnosis of pneumonia on 12/9/17. The PNMT made no recommendations beyond having nursing staff monitor his lung sounds for 30 days. During this time, Center staff changed his liquid consistency back to thin from the nectar-thick liquids the hospital staff recommended. On 2/7/18, in response to another pneumonia, the PNMT conducted another review. The hospital staff completed another swallow study, and again, the hospital staff changed him back to nectar-thick liquids. Upon review, the PNMT stated the emesis was the "root cause," and did not investigate or discuss the possibility that thin liquids might have been the etiology of the pneumonias. The review listed action steps, such as a HOBE evaluation, and revision of oral care instructions, but based on the documents submitted, evidence was not found to show that these occurred.

f. As the Monitoring Team has discussed with State Office, without signature pages that include dates, it is not possible to determine which members of the PNMT participated in the PNMT assessments.

e. It was positive that as needed, an RN Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results.

h. As noted above, five individuals who should have had comprehensive PNMT assessments did not. The following summarizes some of the concerns noted with Individual #416's PNMT assessment:

- While the assessment listed the medications prescribed, it did not note if Individual #416 experienced any of these side effects, and/or whether or not they potentially impacted his PNM-functioning. The Monitoring Team found contradictions in the assessment in that the PNMT stated that supports were effective, but then made recommendations to change supports, such as changing meal frequency and positioning. The assessment did not include data to support the PNMT's conclusion that the "root cause" or etiology of the

	individual's aspiration was emesis, which was caused by esophageal dysmotility. The HOBE evaluation was minimal in that it only looked at oxygen saturation levels and did not track emesis data when the individual was in various positions.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. On a positive note, four individuals' PNMPs included all of the necessary components to meet the individuals' needs. With minimal effort and attention to detail, the Habilitation Therapy staff could make the needed corrections to PNMPs, and by the time of the next review, the Center could make good progress on Indicator c. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	44% 4/9	0/1	0/1	0/1	1/1	1/1	0/1	1/1	1/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	0% 0/15	0/1	0/1	0/2	0/2	0/2	0/2	0/2	0/2	0/1
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	17% 3/18	0/2	0/2	1/2	0/2	0/2	1/2	1/2	0/2	0/2
Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the											

PNMT working with IDTs were responsible for developing. These included IHCPs related to: falls, and weight for Individual #157; fractures, and GI problems for Individual #274; choking, and falls for Individual #669; choking, and aspiration for Individual #86; choking, and falls for Individual #327; aspiration, and choking for Individual #256; weight, and aspiration for Individual #435; aspiration, and GI problems for Individual #416; and skin integrity, and aspiration for Individual #331.

a. and b., and d. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP, and/or include preventative physical and nutritional management interventions to minimize the individuals' risks, or action steps to meet the identified goals/objectives.

c. All individuals reviewed had PNMPs and/or Dining Plans. The PNMPs for Individual #86, Individual #327, Individual #435, and Individual #416 included all of the necessary components to meet the individuals' needs. Problems varied across the remaining PNMPs and/or Dining Plans. However, with minimal effort, the Habilitation Therapy staff could make the needed corrections. By the time of the next review, with attention to detail, this indicator is one on which the Center could make good progress. Examples of problems included:

- Individual #157's PNMP did not include his weight risk, but given his recent history of weight loss, and PNMT involvement, the PNMP should highlight this risk for staff. In addition, the PNMP did not reference bathing and toileting. If he was independent, the PNMP should note this fact.
- Individual #274 was at least at medium risk for weight, but the PNMP did not provide a risk level for weight.
- On 2/7/18, Individual #669's IDT met and discussed changing her chair during mealtime to a living room chair, but the PNMP was not revised.
- Individual #256 was at medium risk for weight, and aspiration, but the PNMP did not include either of these risks.
- Individual #331's PNMP stated that he used a tooth brush and toothpaste, which was also what the OT/PT assessment said. However, the PNMT Review, dated 2/7/18, stated: "Recommended IDT to consider reviewing oral care instructions since he is currently using a standard toothbrush/toothpaste/tap water and determine if he needed to be transitioned to suction tooth brushing. IDT declined recommendation reporting that he did not use the toothbrush but a damp wash cloth to clean his mouth." While the PNMP was consistent with the OT/PT assessment, it is not consistent with the IDT's response to the PNMT Review recommendation, and apparently not consistent with what was occurring in home. No documentation was found to show that the IDT and PNMT resolved this discrepancy.

e. and f. The IHCPs reviewed did not identify the necessary clinical indicators, or the triggers and actions to take should they occur.

g. Often, the IHCPs reviewed did not include PNMP monitoring or the frequency needed to address the individuals' needs. The exceptions were for choking for Individual #669, choking for Individual #256, and weight for Individual #435.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	50% 1/2	N/A	N/A	N/A	1/1	N/A	N/A	0/1	N/A	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/2				0/1			0/1		
Comments: a. and b. For Individual #86, the IDT justified the continued use of enteral nutrition in the dysphagia assessment, OT/PT assessment, and IRRF. However, the dysphagia assessment, dated 6/14/17, stated to hold trials of food by mouth until the individual was stable from aspiration, but the submitted documents did not include evidence the IDT discussed the topic again. For Individual #435, the IDT did not complete timely assessments to address eating, and the assessment completed lacked thorough evaluation, because it only covered the oral peripheral components. The IDT had not developed a plan to potentially move the individual beyond the pleasure feedings.										

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: Overall, it was positive that OTs/PTs completed timely assessments for the individuals reviewed. The quality of OT/PT assessments continues to be an area on which Center staff should focus. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	Individual receives timely screening and/or assessment:										

	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/5	N/A	N/A	0/1	0/1	N/A	N/A	0/1	0/1	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/5	0/1	0/1	N/A	N/A	0/1	0/1	N/A	N/A	0/1

Comments: a. Overall, it was positive that OTs/PTs had completed timely assessments for the individuals reviewed. However, Individual #274 did not receive a HOBE evaluation in response to ongoing emesis.

d. The Monitoring Team reviewed comprehensive OT/PT assessments for four individuals. The following summarize some of the problems noted:

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: For three individuals, the assessors listed medications and potential side effects, but did not discuss whether or not the individuals experienced the potential side effects, or if the medications were potentially impacting the individuals' functioning;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living: Individual #86's oral motor/dysphagia assessment lacked a full review of her oral structure outside of the peripheral areas;
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments: Three of the assessments were incomplete, and did not represent a comprehensive assessment of the individuals' strengths and needs (e.g., provided a summary of current supports/plan, or left out current information);
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings: None of the assessments met this criterion. Problems included a lack of monitoring findings, and/or a lack of discussion about and/or revisions to supports that were not effective at minimizing or preventing PNM issues, such as falls, etc.;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services: At times, assessments identified OT and/or PT needs for which supports or services were not recommended, but clinical justification was not offered for not making such recommendations; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need: As noted above, recommendations that should have been made to address individuals' needs were not, and without complete assessments, it was unclear that all individuals' needs were identified.

On a positive note, all of the comprehensive OT/PT assessments the Monitoring Team reviewed included, as applicable:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths were used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports; and
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale).

e. The following summarize some examples of concerns noted with regard to the required components of the five OT/PT updates the Monitoring Team reviewed:

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: Individual #157's update discussed weight risk briefly, but provided no insight into his fall and fracture risk;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: For all five individuals, the updates provided limited discussion, if any, of the impact of medications on OT/PT supports, and/or failed to identify whether or not the individual experienced potential side effects;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day: Individual #274's update often stated skills "continue to remain unchanged," but did not provide the context for this statement. A reader should not need to go back to previous assessments to obtain a picture of the individual's functional status. Individual #327's update did not include an overall functional description of his skills, including, for example, ambulation;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale): Individual #256's update did not describe his adaptive equipment (e.g., mealtime equipment);
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments: Contradictions were identified in Individual #274's update (e.g., need for head-of-bed elevation; need for assistance with tooth brushing). Individual #256's dysphagia consult for his annual update did not provide a comparative analysis of his oral motor status;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: None of the assessments met this criterion. Problems included a lack of monitoring findings or other data to support conclusions, and/or a lack of discussion about and/or revisions to supports that were not effective at minimizing or preventing PNM issues, such as falls, etc. For example, the update for Individual #331 stated that he remained stable and supports were effective, but then mentioned that he had multiple pneumonias and skin breakdown;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services: As noted above, assessments generally lacked the data needed to provide clinical justification regarding the supports individuals had or needed; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Without complete assessments, it was unclear that all individuals' needs were identified.

On a positive note, as applicable, all of the updates reviewed provided:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs; and

- The individual's preferences and strengths are used in the development of OT/PT supports and services.

Outcome 3 – Individuals for whom OT/PT supports and services are indicated have ISPs that describe the individual's OT/PT-related strengths and needs, and the ISPs include plans or strategies to meet their needs.

Summary: ISPs reviewed did not include a summary of how the individuals functioned from an OT/PT perspective. OTs/PTs should work with QIDPs to correct this issue. It was good to see that IDTs reviewed and made changes, as appropriate, to individuals' PNMPs and/or Positioning schedules at least annually, and that most OT/PT programs were incorporated into individuals' ISPs/ISPAs. The Monitoring Team will continue to review these indicators.

#	Indicator	Overall Score	Individuals: 157	274	669	86	327	256	435	416	331
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	82% 9/11	1/1	1/1	1/1	1/1	2/2	1/1	1/1	1/1	0/2
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	50% 2/4	1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	0/2

Comments: a. It is important for staff working with individuals that ISPs include a summary of how the individual functions from an OT/PT perspective.

c. and d. Individual #331's goals/objectives for direct therapy (i.e., walking 75 feet, and sitting upright) were not included in his ISP, or incorporated through an ISPA.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: Individuals reviewed generally had timely communication assessments. However, a number of individuals for whom Speech Language Pathologists (SLPs) should have completed comprehensive assessments only had updates or screenings. In addition, the quality of communication comprehensive assessments and updates needed improvement. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	78% 7/9	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	56% 5/9	1/1	1/1	0/1	0/1	1/1	1/1	0/1	1/1	0/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and	0% 0/3	N/A	N/A	N/A	0/1	N/A	N/A	0/1	N/A	0/1

	supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/5	N/A	N/A	0/1	0/1	0/1	N/A	0/1	N/A	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/4	0/1	0/1	N/A	N/A	N/A	0/1	N/A	0/1	N/A

Comments: a. through c. The following provides information about problems noted:

- Individual #669's last comprehensive communication assessment was completed in 2012. The SLP did not provide clinical justification for completing an update, as opposed to a comprehensive assessment, since it had been five years. It would have been important for the SLP to fully assess the individual's high-level communication skills, such as reasoning and problem-solving.
- For Individual #86, the SLP only conducted a screening, which did not address the possibility of expanding her skills or using AAC devices.
- Individual #435's screening identified multiple deficits that could have been the focal point of therapy. However, outside of staff strategies, the screening did not provide enough investigation into what could be done to increase her language. She should have had a comprehensive assessment.
- Individual #331's screening did not address more complex functioning, such as problem-solving, and memory recall. He should have had a comprehensive assessment.

d. As discussed above, four individuals should have had comprehensive assessments, but did not (i.e., Individual #669, Individual #86, Individual #435, and Individual #331). The following describes some of the concerns with Individual #327's comprehensive assessment:

- A functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills: The assessment provided general information regarding what the individual could and could not do in relation to communication, but did not translate that into a clear functional description;
- A comparative analysis of current communication function with previous assessments: The assessment did not provide data to support statements regarding the individual's expressive and receptive functioning;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from

communication supports and services: The SLP did not fully explore AAC options. During 2017, the individual used the Dynavox, but according to the SLP, the lack of improvement was due to the device often being broken. Towards the end of therapy, Individual #327 showed an improvement of 57% between October and November, but then the SLP said discharge was due to the individual's lack of desire to use the device. This statement appeared to contradict the improvement noted as a result of therapy and was based upon availability of the device. At the same, time the IDT discussed that his existing AAC would no longer be repaired; and

- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Given that the assessment of his communication needs was incomplete, it was unclear whether or not the SLP provided a full set of recommendations to address his strengths and needs.

On a positive note, the assessment provided:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- The individual's preferences and strengths were used in the development of communication supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- The effectiveness of current supports, including monitoring findings; and
- Evidence of collaboration between Speech Therapy and Behavioral Health Services.

e. The following provide examples of concerns noted with regard to the required components of the four communication updates the Monitoring Team reviewed:

- The individual's preferences and strengths are used in the development of communication supports and services: For each of the updates reviewed, individuals had clear preferences, and strengths identified that the SLPs did not use or take into consideration in recommending supports and services (e.g., desire to live independently, interest in electronics, tracking objects, responding to name);
- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills: Across all four updates, SLPs missed opportunities to expand upon the individuals' current communication abilities and skills;
- The effectiveness of current supports, including monitoring findings: Assessments did not provide information about how current communication strategies (i.e., Communication Dictionaries) were effective in bridging the communication gap;
- Assessment of communication needs (including AAC, EC, or language-based) in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication

supports and services: For two individuals, further assessment of AAC or EC possibilities was warranted, but did not occur; and

- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Despite SLPs identifying deficits in communication for the individuals reviewed, the assessments did not include recommendations to address these issues. In addition, given that the assessments of individuals' communication needs were incomplete, it was unclear whether or not additional recommendations were needed to address their strengths and needs.

On a positive note, the updates did sufficiently address:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication; and
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services.

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.

Summary: These indicators will remain in active oversight. However, if the Center sustains its performance with regard to including descriptions of individuals' communication strengths and needs in ISPs, at the time of the next review, Indicator a might move to less oversight.

#	Indicator	Overall Score	Individuals: 157	274	669	86	327	256	435	416	331
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A										

Comments: a. The description in Individual #86's ISP was outdated, and did not reflect her ability to use EC devices.

b. Simply including a stock statement such as "Team reviewed and approved the Communication Dictionary" did not provide evidence of what the IDT reviewed, revised, and/or approved, and/or whether the current Communication Dictionary was effective at bridging the communication gap.

c. As noted elsewhere, assessments did not include a full set of recommendations to address individuals' communication needs as well as their preferences. However, IDTs had included the limited recommendations for interventions in the ISPs of the individuals reviewed.

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.

Summary: Performance decreased since the last review regarding the types of SAPs chosen for individuals (indicators 3 and 4). Collecting reliable data remained a challenge for Denton SSLC. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	227	96	157	159	173	274	543	25
1	The individual has skill acquisition plans.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The SAPs are measurable.										
3	The individual's SAPs were based on assessment results.	26% 7/27	0/3	0/3	0/3	0/3	1/3	3/3	0/3	0/3	3/3
4	SAPs are practical, functional, and meaningful.	22% 6/27	0/3	1/3	0/3	0/3	0/3	1/3	0/3	1/3	3/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	7% 2/27	0/3	1/3	0/3	0/3	0/3	0/3	0/3	1/3	0/3

Comments:
3. Three SAPs were reviewed for each of the nine individuals. Seven of the 27 SAPs were based on assessments. These were the following: Individual #159's learning to arrange hangers and all three of Individual #173 and Individual #25's SAPs. Exceptions were:

- Skills that had been identified as mastered in the individual's functional skills or vocational assessment (Individual #115 - set up work area, sort alphabetically and SAMS, both of which are related to reading; Individual #96 - writing a list and managing a ledger, which are related to writing and math skills, respectively; Individual #157 - clean work space and shaving; and Individual #274 - writing his grandmother's address and completing an application, both related to his reported ability to write).
- Skills that were identified as the individual's current level of performance with the same level of prompting identified in the objective (Individual #227 - write name; Individual #274 - label medications; and Individual #543 - wash hands and play CD).
- Skills that were not assessed or for which a baseline of current performance was not provided (Individual #227 - SAMS; Individual #157 - cook lunch; Individual #159 - tell time and name coins; and Individual #543 - pay for food).
- Individual #96's completing three tasks was a compliance issue, as was Individual #157's cleaning his work area.

4. Six of the 27 SAPs were considered to be practical, functional, and/or meaningful. These were Individual #227's learning the purpose of her medications, Individual #173 learning to stop at the curb, Individual #543 learning to pay for food, and all three of Individual #25's SAPs. In addition to those skills identified as mastered in the functional skills assessment, those in which the objective matched the current level of performance, or which addressed compliance, exceptions were:

- SAPs that did not support the identified goal (e.g., Individual #115 - SAMS SAP; Individual #159 - telling time and arranging hangers; and Individual #173 - brush teeth).
- SAPs that did not address the individual learning the identified skill (e.g., Individual #157 was to learn to turn on the stove, this did not address his learning to cook).
- SAPs that were not functional (e.g., Individual #173 moving snack items from one location to another).

5. Of the 27 SAPs, there was evidence that two had been monitored for data reliability over a six-month period. These were the cleaning workspace SAP for Individual #227 and the wash hands SAP for Individual #543.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.											
Summary: Performance decreased for all three indicators compared with the last review for which the three indicators were scored at 100%, 56%, and 89%, respectively. The Center should re-visit the way it manages these important foundational aspects of skill training planning. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	115	227	96	157	159	173	274	543	25

		Score									
10	The individual has a current FSA, PSI, and vocational assessment.	56% 5/9	1/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1	0/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	22% 2/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1
12	These assessments included recommendations for skill acquisition.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

10. Five of the nine individuals (Individual #115, Individual #227, Individual #96, Individual #159, Individual #274) had current assessments. Individual #157's functional skills assessment was incomplete and no vocational skills were assessed for Individual #173, Individual #543, or Individual #25. It should be noted that an attempt was made to assess Individual #25's work skills, but this proved unsuccessful.

11. Assessments were available to the IDT 10 days prior to the ISP meeting for two of the nine individuals (Individual #173, Individual #25).

12. Recommendations for skill acquisition were not provided in both the functional skills assessment and vocational assessment for any of the nine individuals.

In some cases, this indicator was rated as zero because the SAPs that were recommended were skills the individual reportedly could perform (e.g., Individual #227 - vocational SAP; Individual #157 - vocational SAP; and Individual #274 - functional skills assessment).

For both Individual #173 and Individual #25, the vocational assessment indicated that the individual would need to develop basic skills before he could attempt a work placement. It is suggested that building these basic skills should be part of any vocational program, particularly for young men who no longer attended school.

Domain #3: Individuals in the Target Population will achieve optimal physical, mental, and behavioral health and well-being through access to timely and appropriate clinical services.

This domain contains 38 outcomes and 169 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the time of the last review, 17 of these indicators, including one entire outcome, had sustained high performance scores and moved to the category requiring less oversight. Presently, five additional indicators will move to the category of less oversight in restraints, psychiatry, and dental, which completes the entirety of Outcomes 1 and 8 in psychiatry.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

Goals/Objectives and Review of Progress

The Monitoring Team looks for nine components of the psychiatric quarterly review. One of the examples, regarding Individual #115, included all the necessary components. Most quarterly documentation was missing one to two of the required elements. The psychiatrists adequately documented consultation with the neurologist. The neurology documentation, however, was sparse.

PBSPs need to be updated when there are changes made in any aspect of programming. Progress notes for behavioral health/PBSP status were done for all individuals each month. That being said, the quality/content of the notes needs to be improved, as do the graphic summaries of the data. Peer review was occurring, at close to the required minimum frequencies. Recommendations that came from peer review were not implemented.

Behavioral health services staff need to review the data collection systems for each individual as well as the methodology to assess (and ensure) data collection timeliness, reliability, and treatment integrity.

Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress with regard to individuals' physical and/or dental health. In addition, integrated progress reports with data and analysis of the data generally were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

Acute Illnesses/Occurrences

Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected.

The Center should continue to work to ensure that nurses timely notify PCPs of acute issues, and that PCPs conduct and document thorough assessments and follow-up of acute issues addressed at the Center. Although continued work was needed, since the last review, some improvement was noted with the PCP or provider's completion of assessments and IPNs related to individuals who were transferred out of the Center to the ED or hospital, as well as with the Center's communication with hospital staff.

Regarding occurrences of more than three restraints in any rolling 30-day period, most of the components were not at criterion, especially those regarding regular review and the required content. At this point, these components should be at criterion.

In psychiatry, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals.

Implementation of Plans

Psychiatry clinics were observed. They were well run and organized. The psychiatrists regularly reviewed the data provided by behavioral health services and by nursing. The psychiatrists did a good job of reviewing all the information and making decisions.

The Polypharmacy committee meeting was observed while the Monitoring Team was on site. It included a brief overview and discussion of regimens. The Center should ensure that individuals who are taking anti-seizure medications are properly categorized for polypharmacy based on dual usage. The Monitoring Team does not monitor for the number of individuals who are categorized as having a polypharmacy medication regimen; rather the Monitoring Team monitors for how those individuals' cases are reviewed and handled.

In behavioral health services, without reliable data, the Monitoring Team could not make a valid determination of progress. The Center's own data, however, indicated no progress for seven of the nine individuals. For these individuals, the Center recommended corrective actions, but the actions were not implemented for five of the seven.

There was no evidence that a sufficient number of staff were trained on individuals' PBSPs and a low percentage of plans had summaries written for float staff.

As noted above, for individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs for nursing supports due to lack of inclusion of regular assessments in alignment with nursing guidelines and current standards of care. As a result, data often were not available to show implementation of such assessments. In addition, for the individuals reviewed, evidence was generally not provided to show that IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly.

For 12 out of 18 chronic or at-risk conditions reviewed, individuals had medical assessment, tests, and evaluations consistent with current standards of care, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate. However, some significant concerns were noted, including lapses in interdisciplinary communication that impacted care and potentially resulted in the amputation of an individual's toe.

Since the last review, for the consultations reviewed, improvement was noted with regard to the PCPs completing timely reviews, indicating agreement or disagreement with a rationale, and writing orders for agreed-upon recommendations. The Center should focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

The Center should focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

It was positive that individuals reviewed, for whom it was applicable, received prophylactic care twice a year, the individuals or staff received tooth-brushing instruction twice a year, restorative work was completed timely, and those individuals that needed extractions had them only when restorative options were exhausted. The Center should focus on ensuring that individuals with medium or high caries risk ratings receive two fluoride applications per year.

It was good to see that most individuals' adaptive/assistive equipment was the proper fit.

Based on observations, there were still numerous instances (70% of 43 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
Summary: Most of the indicators did not meet criteria, especially those regarding regular review and the required content. At this point, these components should be at criterion. An IDT meeting did not occur for this individual; this needs to return to high performance in order for indicator 18 to remain in the category of less oversight after the next review. The crisis intervention plan, however, was at criterion for this and past reviews, too. Therefore, indicator 27 will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	96								
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	0% 0/1	0/1								
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/1	0/1								
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address	0% 0/1	0/1								

	them.										
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	0% 0/1	0/1								
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	0% 0/1	0/1								
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).										
26	The PBSP was complete.	N/A	N/A								
27	The crisis intervention plan was complete.	100% 1/1	1/1								
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	0% 0/1	0/1								
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	0% 0/1	0/1								
Comments: 18-19. Individual #96 experienced more than three restraints in a rolling 30-day period. There was, however, no evidence of a meeting of his IDT within 10 days of the last restraint. There was a meeting held on 3/1/18 during which the events surrounding the last restraint were discussed. This was not a review of the multiple restraints											

implemented during the identified dates.

20-23. During the identified ISPA meeting, there was no discussion regarding the potential role of Individual #96's adaptive skills, or his biological, medical, and psychosocial issues. As the events resulting in restraint were reviewed, there was a discussion of contributing environmental variables, potential environmental antecedents, and variables potentially maintaining the dangerous behavior. No specific actions were recommended to address these (or a comment as to why actions were not to be taken).

24-27. At the time of repeated restraint, Individual #96 had a current PBSP and CIP. Review of his PBSP can be found in the psychology/behavioral health sections of this report. It was determined that his CIP was complete. An individualized restraint had been approved for him. Approvals had been obtained between May 2017 and July 2017. The approval form was incomplete because the time frame for use of this individualized restraint was not indicated. This form referenced his original CIP for detail/illustrations. The original CIP was signed and dated July 2017. Staff were advised not to threaten or coerce Justin, and to not threaten to call the police. These should be standard practices and should not require direct instructions to staff.

28. There was no evidence that treatment integrity had been assessed in December 2017 or January 2018. Further, documentation provided indicated that treatment had not been assessed over a six-month period (August 2017-January 2018).

29. There was no evidence that the IDT had reviewed his PBSP.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.												
Summary: None of the individuals in the review groups who were not already receiving psychiatric services had a change of status warranting re-admission. Given the long-standing correct implementation of Reiss scales, the Monitor will move indicators 2 and 3 into the category of requiring less oversight, too.			Individuals:									
#	Indicator	Overall Score										
1	If not receiving psychiatric services, a Reiss was conducted.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to	N/A										

	psychiatry, or a Reiss was conducted.										
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A									

Comments:
1-3. Reiss scales were used for the five individuals in the review groups who were not already receiving psychiatric services. None of these five had a change of status that required re-administration of the Reiss.

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.

Summary: Without reliable data, progress could not be determined. The Monitoring Team, however, acknowledges that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments: 7
8-9. With some improvement in the set of goals as noted in the comments for indicators 4 and 5, and with collection of reliable data as noted in the comments for indicator 7, progress can be determined. This was not yet the case at Denton SSLC.

10-11. Despite the absence of measurable goals, it was apparent that when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (e.g., medication adjustments and alterations to non-pharmacological interventions) were developed and implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
Summary: Improvement was seen in both indicators. Both will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
Comments: 23. The psychiatric documentation referenced the behavioral health target behaviors as well as the psychiatric symptoms for monitoring. The functional assessment discussed the role of the psychiatric disorder upon the presentation of the behaviors. For Individual #157, the functional assessment was out of date as it was dated 1/10/17. 24. There was documentation that the psychiatric provider participated in the development of the PBSP for the eight individuals who had a current PBSP.											

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.											
Summary: Indicator 27 has sustained high performance and will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
26	Frequency was at least annual.										
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 2/2	N/A	N/A	N/A	1/1	1/1	N/A	N/A	N/A	N/A

Comments:
27. These indicators applied to two of the individuals, Individual #157 and Individual #159. The psychiatrists adequately documented consultation with the neurologist. The neurology documentation, however, was sparse. It only noted that the individual was seen in clinic and what the plan for continuing the medication or follow-up would be.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary:			Individuals:								
#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
33	Quarterly reviews were completed quarterly.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
34	Quarterly reviews contained required content.	11% 1/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
34. The Monitoring Team looks for nine components of the quarterly review. One of the examples, regarding Individual #115, included all the necessary components. The evaluations were missing one to two of the required elements.

35. During the monitoring visit, psychiatry clinics were observed for six individuals, Individual #193, Individual #372, Individual #765, Individual #570, Individual #25, and Individual #353. One of these individuals, Individual #25, was in the review group.

There were challenges noted in the psychiatry clinics as data focused on in clinic were generally regarding behavioral target behaviors not psychiatric symptoms or indicators. Overall, the psychiatrists did a good job of reviewing the available information and attempting to make data based decisions. The psychiatrists reviewed the medication side effect assessments (e.g., MOSES and AIMS) as well as laboratory examinations.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overa	115	227	96	157	159	173	274	543	25

		ll Score									
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	56% 5/9	0/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1	0/1

Comments:

36. There were some delays in both assessments and the prescriber review of the assessments:
- Regarding Individual #115, the AIMS dated 3/3/17 was not reviewed by the prescriber.
- Regarding Individual #159, the MOSES dated 7/25/17 was not signed as reviewed by the prescriber.
- Regarding Individual #543, there was an AIMS performed 4/19/17 with the next assessment dated 8/8/17. There should have been an assessment performed in July 2017. The AIMS and MOSES assessments dated 12/29/17 were not reviewed by the prescriber until 1/24/18.
- Regarding Individual #25, the AIMS dated 12/22/17 was not signed as reviewed by the prescriber. The MOSES dated 12/22/17 was not reviewed by the prescriber until 1/8/18, a total of 16 days.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
Summary:			Individuals:								
#	Indicator	Overall Score									
37	Emergency/urgent and follow-up/interim clinics were available if needed.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?										
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?										
Comments:											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: All four important indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 42. The behavior support program for Individual #157 was out of date as it was implemented 1/10/17.											

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.											
Summary: Indicator 46 will remain in active monitoring. One individual was not reviewed by polypharmacy.			Individuals:								
#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
45	There is a tapering plan, or rationale for why not.										
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	80% 4/5	N/A	1/1	1/1	N/A	0/1	N/A	1/1	N/A	1/1
Comments: 46. These indicators applied to five individuals. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for four of the individuals in the review group meeting criteria for polypharmacy. There was no documentation regarding Individual #159. The polypharmacy committee meeting was observed during the visit. There was a need for improvement with regard to the review and justification of the regimens. This meeting should be a brisk discussion of the regimens with the psychiatrist presenting the justification of polypharmacy for critique.											

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Without reliable data, the Monitoring Team could not make a valid determination of progress. Therefore, indicator 6 was scored 0 for all individuals. The Center's own data, however, indicated no progress for seven of the nine individuals. For these seven individuals, the Center recommended corrective actions (indicator 8). This was good to see, however the actions were not implemented for five of the seven (indicator 9).			Individuals:								
#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
6	The individual is making expected progress	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	100% 7/7	N/A	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
9	Activity and/or revisions to treatment were implemented.	29% 2/7	N/A	0/1	1/1	0/1	0/1	N/A	1/1	0/1	0/1

Comments:

6. Although graphs included in the progress notes for Individual #115 and Individual #173 suggested improving behavior, this indicator was rated as zero for all individuals due to problems with data reliability (i.e., indicator 5). Graphs indicated a lack of progress for Individual #227, Individual #96, Individual #157, Individual #159, Individual #274, Individual #543, and Individual #25.

7. Based upon the data provided, none of the individuals had met their goals/objectives. It should be noted that no goals were identified in Individual #227's behavioral health assessment or PBSP.

8. For seven individuals, corrective actions had been recommended. This included increased monitoring and/or training of staff (Individual #157, Individual #25), an introduction or change in a token system (Individual #96, Individual #159, Individual #274), staff interview to determine triggers following a recent increase in aggression (Individual #543), or the development and implementation of a PBSP (Individual #227).

9. For two of the seven individuals (Individual #96, Individual #274) was there evidence that action plans had

been implemented. For both Individual #157 and Individual #25, there was no evidence of the assessment of treatment integrity, and records indicated that a small percentage of staff had been trained. Individual #159's informal token system was not described and, therefore, it could not be determined if and when this had been implemented. There was no review of information gleaned from interviewing Individual #543's staff. Lastly, although a PBSP was eventually implemented for Individual #227, this is rated zero because it occurred four months after her admission to the Center.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.

Summary: There was no evidence that a sufficient number of staff were trained on individuals' PBSPs. Similarly, a low percentage of PBSPs were written/developed by a BCBA (or as detailed in indicator 18) and a low percentage of plans had summaries written for float staff. These three indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
17	There was a PBSP summary for float staff.	67% 6/9	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	44% 4/9	0/1	1/1	0/1	1/1	0/1	1/1	1/1	0/1	0/1

Comments:

16. Based upon the documentation provided, it was determined that 80% or greater of assigned home staff had been trained on the PBSP for one of the individuals (Individual #159). For all others, there was evidence that between 7% (Individual #157) and 63% (Individual #96) of their home staff had been trained. The behavioral health services director reported that additional staff had been trained, but staff could not readily access this information. Although an attempt was made to provide additional documentation, it was reported that a clear spreadsheet could not be presented. It is expected that this would be in place by the next monitoring visit.

17. For six individuals, a PBSP summary was available for float staff. The exceptions were documents that did not summarize the plan (Individual #115), a summary that did not address all targeted problem behaviors (Individual #25), and no summary provided (Individual #159). Staff are advised to date the summary to ensure it corresponds to the current PBSP.

18. For four of the individuals, there was evidence that their FBAs and PBSPs had been written by a BCBA. The exceptions were plans written by a staff member who was enrolled in or completing coursework towards certification. This included the plans for Individual #115, Individual #96, and Individual #159. It was not clear whether the behavioral health specialist who had written the FBAs and PBSPs for Individual #543 and Individual #25 was still enrolled in coursework towards certification. There was no evidence that a BCBA had reviewed and signed off on any of these assessments and plans (this is specified in the scoring interpretive guidelines).

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.

Summary: Progress notes for behavioral health/PBSP status were done for all individuals each month. That being said, the quality/content of the notes needs to be improved. Similarly, graphic summaries of the data also needed improvement so that they could be useful for making treatment decisions (and for determining progress). Some data were available in clinical meetings, but they were incomplete or inaccurate. Peer review was occurring, at close to the required minimum frequencies. Recommendations that came from peer review were not implemented. This set of indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
19	The individual's progress note comments on the progress of the individual.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The graphs are useful for making data based treatment decisions.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	0/1
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	0% 0/3	0/1	N/A	0/1	N/A	N/A	N/A	0/1	N/A	N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	0%									

Comments:

19. The monthly progress notes for all nine individuals commented on the individual's progress, however, note the following:

In some cases, statements were made in support of interventions without evidence that the data had been analyzed to objectively determine the intervention's effectiveness. Examples included token programs for Individual #96 and Individual #274, and the use of a weighted blanket with Individual #159.

Moving forward, staff are advised to make changes to PBSPs when new or revised interventions are introduced and to ensure that phase change lines are added to graphs to allow for objective assessment of treatment efficacy.

Staff are advised to label day programs accurately when reporting on the individual's participation. Referencing employment/work when the individual is actually enrolled in a life skills program is misleading as it implies that he or she is working. For example, Individual #25's attendance at workshop was noted, but he did not participate in any vocational program.

20. Although graphs were included in all progress notes, none of these were considered useful for making data-based decisions.

- Problems included graphs that depicted too many target behaviors (Individual #115, Individual #227, Individual #96, Individual #157, Individual #159, Individual #173, Individual #274).
- In other cases, phase change lines were not always included to depict changes in medication or PBSP implementation (Individual #157, Individual #173, Individual #274, Individual #543, Individual #25).
- Staff are advised to label the horizontal axis as months rather than as review periods (Individual #115, Individual #227).
- In Individual #543's most recent progress note, the graphs indicated that one of his psychiatric indicators, repetitive activity, had not occurred over the past six months, but during observations, he was consistently displaying this behavior.
- In Individual #25's progress note, there was a lack of correspondence between restraint data reported in the text versus that displayed in the graph and table.

21. An observation was conducted by the Monitoring Team during the psychiatric clinic for Individual #25. Although data were reviewed through the end of February 2018, there were no data presented for the current month. Further, problems with the accuracy of the data were evident as noted in indicator 5 above. During the ISP meeting for Individual #543, the QIDP reported that the individual had not displayed problem behavior for the past year. The graphs in his progress notes did not reflect this, yet the behavioral health specialist did not comment to correct this statement.

22. There was evidence that three of the individuals had been reviewed in either external peer review and/or internal peer review.

- For one of these individuals, Individual #96, the meeting minutes did not include a summary of

recommendations.

- Recommendations for Individual #115 included whether she would have a positive response to a punching bag doll or responding to her expressed interest in dance classes. Further, an electronic restriction was suggested. There was no evidence that any of these recommendations had been addressed. The recommendation to involve her in counseling services was addressed as she reportedly began this intervention in March 2018.
- Recommendations for Individual #274 included use of the debit card provided by his grandmother contingent upon positive behavior and the development of a behavior contract with his input. Although his BCBA reported changes to his reinforcement plan, there was no evidence that either of these recommendations had been addressed.

23. Based upon the documentation provided by the facility, it was determined that external peer review had occurred six times over a six-month period. However, during this same six-month period, internal peer review had occurred 16 times, twice monthly for three months, three times monthly for two months, and four times during one month.

Outcome 8 – Data are collected correctly and reliably.

Summary: Behavioral health services needs to review the data collection systems for each individual as well as the methodology to assess (and ensure) data collection timeliness, reliability, and treatment integrity. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
3	If the individual has a PBSP, goal frequencies and levels	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

0	are achieved.	0/9									

Comments:
26-27. Due to the problems regarding data accuracy, it was determined that the data systems used to measure target and replacement behaviors identified in the PBSPs were not adequate.

28-29. The facility had yet to establish acceptable measures of data timeliness. Although the electronic record data entry system was programmed to display a light every two hours, there was no evidence that this resulted in timely recording.

Inter-observer agreement and treatment integrity were reportedly assessed via observation. (Though documentation indicated that treatment integrity had been assessed via interview alone at least once for Individual #96 and for Individual #274). This was to occur at a minimum of once monthly, with an acceptable level established at 80%. Reports in the PBSP did not always include the dates of assessment, often reflected 100% IOA for nonoccurrence, and did not provide data to indicate treatment integrity.

30. There was evidence of monthly assessment of IOA for Individual #274. Treatment integrity had not been assessed each month for any of the nine individuals. In four cases (Individual #157, Individual #159, Individual #543, Individual #25), there was no evidence of treatment integrity assessment over the six-month period.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant and achievable outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	11% 2/18	0/2	0/2	0/2	0/2	1/2	0/2	1/2	0/2	0/2
c.	Integrated ISP progress reports include specific data	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	reflective of the measurable goal(s)/objective(s).	0/18									
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #157 – fluid imbalance, and weight; Individual #274 – cardiac disease, and weight; Individual #669 – circulatory, and falls; Individual #86 – respiratory compromise, and GI problems; Individual #327 – seizures, and falls; Individual #256 – GI problems, and constipation/bowel obstruction; Individual #435 – UTIs, and respiratory compromise; Individual #416 – GI problems, and constipation/bowel obstruction; and Individual #331 – diabetes, and skin integrity).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #327 – falls, and Individual #435 – UTI.

c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports on these goals with data and analysis of the data often were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provision of medical supports and services to these nine individuals.

Outcome 4 – Individuals receive preventative care.

Summary: All nine individuals reviewed received the preventative care they needed. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to preventative care can be assessed, and are deemed to meet the requirements of the Settlement Agreement. In addition, the Center needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

Individuals:

#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331

a.	Individual receives timely preventative care:										
	i. Immunizations	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 7/7	N/A	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
	iii. Breast cancer screening	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
	iv. Vision screen	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	100% 6/6	N/A	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1
	vii. Cervical cancer screening	100% 2/2	N/A	N/A	1/1	1/1	N/A	N/A	N/A	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	0% 0/8	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1
Comments: a. Overall, the individuals reviewed received timely preventive care, which was good to see. b. As noted in the Medical Audit Tool, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence needs to be present that the prescribing medical practitioners have addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.										

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	50% 1/2	N/A	N/A	N/A	0/1	N/A	N/A	1/1	N/A	N/A
Comments: a. In the most recent years, Individual #86 had pneumonia on 9/5/16, 5/21/17, 6/9/17, 9/18/17, and											

10/1/17. On 7/17/17, she received a tracheostomy. On 6/13/17, she was given an out-of-hospital (OOH) DNR. As discussed in further detail below, given that she had been stable clinically for several months recently, along with the lack of discussion concerning next steps and potential surgical treatment of her reflux to prevent further aspiration pneumonia, her IDT and the Ethics Committee should re-review her DNR status. DNR Orders are appropriate when all treatment modalities have been considered and implemented as appropriate, but little documentation was submitted to show whether or not her severe reflux, which contributed to her several recent bouts of aspiration pneumonia, had been addressed.

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: The Center should continue to work to ensure that nurses timely notify PCPs of acute issues, and that PCPs conduct and document thorough assessments and follow-up of acute issues addressed at the Center. Although continued work was needed, since the last review, some improvement was noted with the PCP or provider's completion of assessments and IPNs related to individuals who were transferred out of the Center to the ED or hospital, as well as with the Center's communication with hospital staff. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	62% 8/13	1/2	2/2	1/1	0/2	2/2	N/A	2/2	N/A	0/2
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	70% 7/10	1/2	2/2	1/1	N/A	1/1		0/2		2/2
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	67% 8/12	1/1	0/1	N/A	0/2	2/2	N/A	2/2	2/2	1/2

d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	75% 3/4	1/1	0/1		N/A	N/A		1/1	N/A	1/1
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	Due to the Center's sustained performance, this indicator was moved to the category requiring less oversight.									
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	73% 8/11	1/1	1/1		1/1	1/2		0/2	2/2	2/2
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	67% 2/3	N/A	N/A		1/1	N/A		0/1	1/1	N/A
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	100% 11/11	1/1	1/1		1/1	2/2		2/2	2/2	2/2

Comments: a. For seven of the nine individuals reviewed, the Monitoring Team reviewed 13 acute illnesses addressed at the Center, including: Individual #157 (left lip skin tear on 9/1/17, and hives on 11/8/17), Individual #274 (right axilla swelling on 9/1/17, and allergy symptoms on 9/18/17), Individual #669 (bruise to left great toe on 9/10/17), Individual #86 (eye drainage on 1/2/18, and ear drainage on 1/30/18), Individual #327 (cellulitis on 8/1/17, and fractured right hand on 8/7/17), Individual #435 (facial edema on 10/6/17, and conjunctivitis on 10/9/17), and Individual #331 (toe ulcer on 8/8/17, and increased redness of left 4th toe on 9/18/17).

PCPs or other providers did not assess the following acute issues according to accepted clinical practice: Individual #157 (left lip skin tear on 9/1/17), Individual #86 (eye drainage on 1/2/18, and ear drainage on 1/30/18), and Individual #331 (toe ulcer on 8/8/17, and increased redness of left 4th toe on 9/18/17). At times, PCPs did not document the source of the information.

b. For the following acute issues, the PCPs or other providers did not conduct follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized: Individual #157 (left lip skin tear on 9/1/17), and Individual #435 (facial edema on 10/6/17, and conjunctivitis on 10/9/17).

The following provide examples of concerns noted:

- According to nursing documentation, on 9/1/17 at 8:08 p.m., Individual #157 sustained an injury to his lip due to peer-to-peer aggression. The PCP's first IPN related to the injury was entered on 9/6/17 at 9:09 a.m. It was unclear when nursing staff notified the PCP that the individual needed to be seen. The injury

occurred over a long holiday weekend. The PCP prescribed the use of oral gel, and saline three time a day for three weeks with follow-up the following week. The PCP did not document any follow-up.

- Although the submitted documents did not contain a nursing IPN for Individual #435's facial edema, a PCP IPN, dated 10/9/17 at 9:05 a.m., described the PCP's assessment. The PCP ordered a comprehensive metabolic panel (CMP). The documentation did not show that the PCP assessed the individual's lab results in the context of the edema.

- Although the submitted documents did not contain a nursing IPN for Individual #435's signs and symptoms of conjunctivitis, a PCP IPN, dated 10/9/17 at 9:47 a.m., described purulent nasal drainage, and red eyes with discharge. The plan was to obtain a complete blood count (CBC), ciprofloxacin ophthalmic solution, and Augmentin by gastrostomy tube (G-tube). Based on the documentation submitted, the PCP did not complete follow-up on the lab results or resolution of the conjunctivitis and the purulent nasal discharge.

- On Tuesday, 8/8/17, a nursing IPN noted that Individual #331 had a toe ulcer. On Saturday, 8/12/17, a provider first saw the individual for the toe ulcer, and ordered Mepilex Ag and Augmentin for seven days. On Monday, 8/14/17, the PCP followed up, and added Norco. On the same day, the wound care nurse saw him, and noted the individual pulled the nail off of the fourth left toe. It was not until 8/18/17, that the PCP again saw Individual #331, and sent him to the ED for treatment of cellulitis, which is discussed in further detail below.

c. For seven of the nine individuals reviewed, the Monitoring Team reviewed 12 acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #157 (ED visit for reaction to a medication on 1/20/18), Individual #274 (ED visit for seizure on 9/5/17), Individual #86 (Infirmary admission of sputum change on 9/9/17, and hospitalization for pneumonia on 9/18/17), Individual #327 (ED visit for laceration of finger on 8/7/17, and ED visit for fracture of right hand on 8/8/17), Individual #435 (hospitalization for hypoxia on 9/5/17, and ED visit for hypoxia on 9/14/17), Individual #416 (hospitalization for sepsis on 10/24/17, and hospitalization for fever and tachycardia on 10/30/17), and Individual #331 (ED visit for cellulitis of the foot on 8/18/17, and ED visit for hypoxia on 8/21/17).

c. through e., g., and h. The following provide examples of the findings for these acute events:

- It was positive to see that the following individuals displaying signs/symptoms of acute illness received timely acute medical care, and follow-up care: Individual #157 (ED visit for reaction to a medication on 1/20/18), Individual #327 (ED visit for laceration of finger on 8/7/17), Individual #416 (hospitalization for sepsis on 10/24/17, and hospitalization for fever and tachycardia on 10/30/17), and Individual #331 (ED visit for hypoxia on 8/21/17).

- On 9/5/17 at 8:30 a.m., Individual #274's PCP ordered transfer to the ED due to a seizure. Based on documentation submitted, no note was found to show that the PCP or another provider assessed the

individual between 8:30 a.m. and 10:35 a.m., when he left with emergency medical services (EMS). Later, on 9/5/17, the PCP reviewed the ED tests. Individual #274 left the Infirmary to walk around campus, and refused to see the PCP. According to the PCP's notes, on 9/6/17, the individual refused to come to the clinic for further follow-up.

- In response to Individual #86's after-hours Infirmary admission on 9/9/17 for sputum changes (i.e., the home's humidifier was not functioning), and hospitalization for pneumonia on 9/18/17, the PCP did not write IPNs within one business day.

- For the following acute events, documentation was not found to show that a PCP or nurse communicated necessary clinical information with hospital staff: Individual #327 (ED visit for fracture of right hand on 8/8/17), and Individual #435 (hospitalization for hypoxia on 9/5/17, and ED visit for hypoxia on 9/14/17).

- As noted above, on Tuesday, 8/8/17, a nursing IPN noted that Individual #331 had a toe ulcer. On Saturday, 8/12/17, a provider first saw the individual for the toe ulcer, and ordered Mepilex Ag and Augmentin for seven days. On Monday, 8/14/17, the PCP followed up, and added Norco. On the same day, the wound care nurse saw him, and noted the individual pulled the nail off of the fourth left toe. It was not until 8/18/17, that the PCP saw Individual #331 again, and sent him to the ED for cellulitis. Documentation stated that Augmentin resolved the infection on 8/19/17, when it was changed to Rocephin IM until 8/25/17. Then, on 8/26/17, he was hospitalized for recurrent cellulitis of the toe.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.

Summary: Since the last review, for the consultations reviewed, improvement was noted with regard to the PCPs completing timely reviews, indicating agreement or disagreement with a rationale, and writing orders for agreed-upon recommendations. The Center should focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	80% 12/15	2/2	2/2	2/2	0/2	2/2	1/1	2/2	N/A	1/2

b.	PCP completes review within five business days, or sooner if clinically indicated.	87% 13/15	2/2	2/2	0/2	2/2	2/2	1/1	2/2		2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	80% 12/15	2/2	2/2	2/2	0/2	2/2	1/1	2/2		1/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	100% 13/13	2/2	1/1	2/2	2/2	2/2	1/1	1/1		2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A		N/A

Comments: For eight of the nine individuals reviewed, the Monitoring Team reviewed a total of 15 consultations. The consultations reviewed included those for Individual #157 for neurology on 9/13/17, and eye clinic on 11/2/17; Individual #274 for orthopedics on 8/22/17, and gastroenterology (GI) on 10/31/17; Individual #669 for ear, nose, and throat (ENT) on 1/23/18, and gynecology on 1/8/18; Individual #86 for pulmonary on 8/24/17, and urology on 9/12/17; Individual #327 for orthopedics on 8/24/17, and neurology on 9/13/17; Individual #256 for neurology on 12/6/17; Individual #435 for pulmonary on 12/11/17, and nephrology on 9/11/17; and Individual #331 for cardiology on 8/18/17, and hematology on 8/10/17.

a. For many of the consultation reports reviewed, PCPs indicated agreement or disagreement with the recommendations, and provided rationales for disagreements. The exceptions were the consultations for Individual #86 for pulmonary on 8/24/17, and urology on 9/12/17; and Individual #331 for cardiology on 8/18/17.

b. Only two of these reviews did not occur timely (i.e., Individual #669 for ear, nose, and throat (ENT) on 1/23/18, and gynecology on 1/8/18).

c. The PCP IPNs related to the consultations reviewed that did not include all of the components State Office policy requires were for Individual #86 for pulmonary on 8/24/17, and urology on 9/12/17; and Individual #331 for cardiology on 8/18/17._

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, which was good to see.

e. For Individual #86's urology consultation on 9/12/17, the PCP did not indicate in the IPN whether or not the IDT should meet, but based on the consultation findings, the IDT should have met.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.

Summary: Although since the last review, some improvement was noted with this indicator, concerns with the provision of medical assessments, tests, and evaluations continued to place individuals at risk. This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	67% 12/18	2/2	1/2	1/2	1/2	1/2	2/2	2/2	2/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #157 – fluid imbalance, and weight; Individual #274 – cardiac disease, and weight; Individual #669 – circulatory, and falls; Individual #86 – respiratory compromise, and GI problems; Individual #327 – seizures, and falls; Individual #256 – GI problems, and constipation/ bowel obstruction; Individual #435 – UTIs, and respiratory compromise; Individual #416 – GI problems, and constipation/bowel obstruction; and Individual #331 – diabetes, and skin integrity).

a. For 12 out of 18 chronic or at-risk conditions reviewed, individuals had medical assessment, tests, and evaluations consistent with current standards of care, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate. However, some significant concerns were noted, including lapses in care that potentially resulted in the amputation of an individual's toe. The following provide examples of concerns noted:

- Individual #274 continued to gain weight. His estimated desirable weight range was 176 to 216 pounds. In September 2016, his admission weight was 276 pounds, and most recently, in March 2018, he weighed 346 pounds. He was prescribed an 1800- to 2200-calorie diet with an 8:00 p.m. snack. He frequently requested substitutes for his menu, and often chose calorie-dense foods and beverages. His family frequently brought him additional snacks that were not consistent with his diet, and took him home where he overindulged in eating, leading to vomiting from ingestion of excessive amounts of food at one time. His family also provided him with a monthly cash allowance, which he spent on snacks. On 9/19/17, 11/10/17, 11/22/17, 12/19/17, and 1/16/18, the IDT held meetings to address his diet and behaviors. The Dietician counseled the family member bringing in the food about his diet and snacks that are appropriate. At times, Individual #274 went off campus to ingest alcohol. Most recently, he started an exercise program and the success of his participation will be measured over time. Recently, psychiatry changed his antidepressant medication. Given his obesity, his risk for obstructive sleep apnea was increased, but he currently had no documented signs or symptoms of this disorder. The submitted documents did not reflect the role of Behavioral Health Services staff in addressing his ongoing behavioral challenges related to consumption of food. It appeared that most of the IDT's response to his unwillingness to comply with diet and exercise programs had been to

impose more restrictions, which was not conducive to improvement in his behavior. He had a number of interests and past positive experiences (e.g., working at the gym), as well as community contacts that the IDT had not fully evaluated/pursued, but had the potential to self-motivate him to attain a healthier lifestyle. Although the PCP was monitoring his ongoing health and providing treatment for the sequelae of his obesity and food choices (e.g., high cholesterol, high blood pressure), the submitted documentation did not reflect an interdisciplinary approach of sufficient intensity and creativity needed to address his behaviors and lifestyle associated with food volume and choices.

- Based on documentation provided, from 10/20/16 to 10/19/17, Individual #669 fell 31 times. As of 9/28/16, she had a normal bone density, with a decrease in density from the prior DEXA of 4/27/14. In 2017, the psychiatrist reduced Zyprexa and added Depakote. In 2017, her therapeutic shoes were replaced. An ISPA, dated 8/1/17, indicated many of her falls were associated with her sliding to the floor in the context of behaviors, and escalated when her bath time was changed. Additionally, when she was in a hurry to get up from sitting, she was at increased risk of falling. According to the IDT, in the past year, most falls that occurred during the day were associated with attention-seeking behavior, but her most recent frequent falls were not associated with attention-seeking behavior. The IDT indicated that her falls were due to her unwillingness to wait for staff assistance, walking without help, and refusing assistance with bathing. She used a wheelchair for long distance outdoors, when unsteady, or unsafe when walking with a gait belt. She used a rolling walker indoors and on the patio. The IDT replaced a wall sensor in her bedroom with a pressure sensor mattress alarm. Bathing time was reverted to the morning to respect her preference.

  The following number of falls were recorded: May 2017 - four falls, June 2017 - one fall, July 2017 - seven falls, August 2017 - eight falls, September 2017 – six falls, October 2017 - one fall, November 2017 - three falls, December 2017 - two falls, January 2018 - three falls. Despite the ongoing behavioral component associated with the falls, a psychiatric progress note, dated 8/15/17, indicated: “there have been no new or emerging symptoms to report. …had a slight increase in both the severity of aggression and target behavior due to staff documentation error… if there is increase in aggression, will consider titrating Depakote.”

  On 8/25/17, the PT initiated therapy after finding a change in physical posturing during transfer, comfort during standing, and a decrease in balance. On 8/28/17, the IDT met and indicated that some of the falls were intentional. A PT note, dated 9/9/17, indicated that Individual #669 had an enthusiastic response to therapy that was challenged by her impulsivity. She also participated in therapy for cervical range of motion. A PT note indicated that her evaluations demonstrated weakness and unsteadiness, as well as lack of environmental awareness. However, during pet therapy, she demonstrated functional range of motion, balance from sitting to standing, core control, and awareness of the environment. She was able to walk 150 feet without a walker or device. On 9/10/17, staff noted that her diabetic socks were compression socks and did not fit her well. On 10/4/17, a bath chair lift was installed for her use.

A behavioral assessment, dated 9/29/17, indicated “no changes from baseline.” An ISPA, dated 10/13/17, indicated Behavioral Health Services staff were to implement data collection on controlled and uncontrolled falls. The Clinical Pharmacist reviewed her medication regimen and concluded it did not contribute to her falls. Her mattress was changed twice until the correct size was placed on her bed’s frame. At the time of the February 2018 eye clinic, her vision was considered adequate.

Throughout 2017, her sodium (Na) level was low, and she was placed on a 2500 cubic centimeter (cc) per day fluid restriction. On 3/21/18, the most recent Na level had increased to 131. The submitted documents did not indicate that the PCP had identified the etiology of her hyponatremia, or conducted an evaluation of this condition to rule out potential causes. The PCP had not addressed the problem of falls in the AMA, dated 11/27/17. The PCP did not recall any falls with injuries, and stated he was not involved with falls without injuries. This was concerning, because any fall placed the individual at significant risk. Given that psychiatric and behavioral issues also potentially impacted the falls, improved communication was needed between the IDT as a whole, and, particularly, the various clinicians involved with Individual #669’s care and treatment.

- Individual #86 had kyphoscoliosis and moderate to severe dysphagia requiring G-tube feeding and enteral nutrition. She received suction tooth brushing. She required head-of-bed elevation, as well as specific wheelchair positioning. In the most recent years, on 9/5/16, 5/21/17, 6/9/17, 9/18/17, and 10/1/17, she had pneumonia. She was not a candidate for Bilevel Positive Airway Pressure (BiPAP), due to her dysphagia and excessive secretions. The consultant pulmonologist indicated that a tracheostomy would relieve her obstructive sleep apnea, as well as not affect her quality of life. On 7/17/17, she received a tracheostomy. The 9/18/17 pneumonia occurred after two episodes of bile-like emesis.

  Individual #86 received her enteral nutrition at 40 milliliters (ml) per hour for 15 hours daily. She had a history of esophagitis, gastritis, and severe reflux to the larynx/pharynx. Additionally, she had a hiatal hernia, partial gastric volvulus, and infantile epiglottis. She was treated with a proton pump inhibitor for her gastroesophageal reflux disorder (GERD). She had prior abdominal surgery to correct a gastrocolic fistula, with total abdominal colectomy and a permanent ileostomy.

  According to the PCP, since her return on 11/3/17, from a long hospitalization and stay at a long term acute care (LTAC) facility for IV antibiotics, Individual #86 had been medically stable. In the submitted documents, the PCP provided no discussion about additional steps to reduce the risk of severe reflux and aspiration pneumonia, such as whether she was a candidate for surgical intervention such as a fundoplication, given her history of prior abdominal surgery. Her last esophagogastroduodenoscopy (EGD) might have been in 2013, and no further evaluation occurred to determine the current severity of her GERD, although her most recent severe pneumonia was preceded by emesis/severe reflux. It appeared she continued to have severe reflux. On 6/13/17, an OOH DNR was put in place. Given that she had been stable clinically for several months recently, along with the lack of discussion concerning next steps and

potential surgical treatment of her reflux in preventing further aspiration pneumonia, the IDT and Ethics Committee should review and update her DNR status. DNR Orders are appropriate when all treatment modalities have been considered and implemented as appropriate, but little documentation was submitted to show whether or not her severe reflux, which contributed to her several recent bouts of aspiration pneumonia, had been addressed.

- In 2017, Individual #327 fell numerous times. On 8/7/17, he fell and fractured his right hand. A treatment note, dated 8/29/17, indicated that he had regressed with transfer ability, requiring more assistance, which was made worse by not wearing his knee brace and not locking his wheelchair. Since then, he fell on: 9/8/17, 9/17/17, 9/18/17, 9/19/17, 10/2/17, 10/27/17, 10/30/17, 11/7/17, 11/20/17 times 2, 11/26/17, 11/30/17, 12/14/17, 1/7/18, 1/11/18 and 1/12/18. Many of these falls were associated with transferring without assistance, sliding off his chair, leaning forward without a seat belt and/or knee brace in use, and not locking his wheelchair. Although one fall resulted in a fracture to his hand, usually, these falls resulted in no injury or minor injury (e.g., scratch, bruise).

  Individual #327 also had a diagnosis of osteopenia, treated with Alendronate. He had osteoarthritis of his left knee, for which he was prescribed a bedtime dose of a nonsteroidal anti-inflammatory drug (NSAID). In February 2017, he was prescribed a new knee brace for his left knee. He was not considered a good candidate for surgery of his knee due to noncompliance with both equipment and guidance/assistance from staff. Habilitation Therapy staff adjusted his wheelchair several times. Both the OT and PT provided formal therapy services focusing on transfers and trunk control. He participated in his PT therapy, and demonstrated the ability to safely transfer when he took his time to do so. The OT suggested that his severe impulsivity was a barrier to progress with direct OT therapy. In November 2017, he attended seven OT sessions and refused four OT sessions. In January 2018, he refused nine sessions. On 1/12/18, the PT installed a bed cane to provide stability during transfers to and from bed. On 1/19/18, during a monitoring visit to his home, habilitation therapy staff noted the staff were not following the PNMP for bathing, and retrained the staff. On 2/1/18, the PT further adapted the leg rests on his wheelchair so they could be removed for transfers. He was prescribed a handled gait belt, but frequently forgot to take it with him to his workshop. As a result, an additional handled gait belt was kept in the workshop and at the life skills program. The IDT added a service objective to his ISP for use of his knee brace.

  Despite the individual's continued impulsivity, psychiatry notes indicated that "indicators are normalized." It would be helpful for the IDT to develop indicators that are sufficiently sensitive to capture the significant psychiatric and psychologic behaviors affecting his daily living. Although an exercise program was offered through Texercise, he refused this activity. The IDT did not then consider additional options to maintain his strength and flexibility. The submitted documents did not identify behavioral interventions to reduce the behaviors impacting his falls. The PCP was not aware of the falls listed above from September onward. Several departments had not completed thorough evaluations and treatments. This was concerning, because any fall placed the individual at significant risk. Given that psychiatric and behavioral issues also

potentially impacted the falls, improved communication was needed between the IDT as a whole, and, particularly, the various clinicians involved with Individual #327's care and treatment.

- Individual #331 had a long history of diabetes mellitus type II, and a history of bilateral moderate proliferative diabetic retinopathy. He received both long-acting insulin in the morning, and rapid-acting insulin three times daily prior to meals based on blood glucose levels. In the past, he had several ED visits for severe hypoglycemia. Until 10/20/16, an endocrinologist followed him, but the specialist deferred further diabetes care to the PCP due to the individual's noncompliance with dietary restrictions. At that time, recommendations were to ensure he did not delay or skip a meal, and that staff needed to maintain diet compliance with the individual. More recently, from 3/7/17 to 3/10/17, he was hospitalized for hypoglycemia. On 8/10/17, his blood glucose in the morning was 58 (asymptomatic), and he was given milk to bring his glucose to 98. On 8/13/17, in the morning, his blood glucose was 76, and again he was given milk with juice (the order, however, indicated nursing intervention should begin with a glucose <70). Most recently, on 1/12/18, he had a blood glucose of 45, and he was given both a glucagon injection and glucose gel. A Hemoglobin (Hgb) A1C on 3/29/17 was 10.4, and on 7/6/17 was 10.0. These elevated levels were due to noncompliance with his diet. A nutrition note, dated 12/18/17, indicated that he continued to work as a greeter at the on-campus diner. A food log had been unsuccessful due to his frequent hospitalizations. Reportedly, staff taught him to understand healthy food choices at the on-campus diner, but he spent his money on alternate foods of his choice. When able, the individual was independent on campus.

  When asked, the PCP indicated she had not observed him directly or indirectly at the on-campus diner. Staff were not able to monitor all of his choices and what he ate when he was away from the home. Additionally, it appeared he missed prescribed snacks at times, which made it difficult to ensure an adequate blood glucose when insulin was administered according to his prescribed schedule. The physiologic stress of repeated pneumonias, as well as osteomyelitis with elevated blood glucose levels added an additional challenge to ensuring adequate blood glucose control. The cardiologist followed him (8/19/17 with follow up in one year), as well as the podiatrist (6/9/17, 9/8/17, and 12/1/17), and ophthalmologist (9/19/17, and 12/19/17). On 11/2/17, the OT provided skilled therapy to improve his activity tolerance, and to teach him energy conservation strategies, safety awareness, and endurance related to his activities of activities of daily living (ADLs).

  Although it was important for him to have monitoring throughout the day to determine the amount, type, and timing of his food and fluid intake, this did not occur. Insulin administration was based on assumptions about a schedule for food and fluid intake, which might not have occurred. Also, he consumed additional calories at various times of the day, which caused additional spikes in his blood glucose levels. The IDT did not develop a plan to measure all his daily intake, which would require close observation (not necessarily direct supervision), and then, base his medical treatment on this level of caloric intake each day, rather than relying on incomplete and inaccurate information. The PCP was unable to regulate Individual #331's

blood glucose due to this unknown information. Although staff educated Individual #331 on healthy choices, his freedom allowed him alternative choices. No information was found regarding the role Behavioral Health Services staff played in motivating him to comply with a healthy lifestyle of food and/or exercise. The Center did not submit documentation indicating that his IDT, with the PCP's input, developed and implemented a long-term formal exercise program that accommodated his physiological and anatomic needs. Although the submitted documentation indicated the IDT discussed alternative work environments as his current location made compliance with diet difficult, the IDT did not document action steps that it pursued.

- On 8/8/17, Individual #331 developed an ulceration of his left 4th toe. The first documentation showing that nursing staff notified a PCP about the ulcer was dated 8/12/17, and indicated that a nurse notified the weekend on-call physician, who ordered treatment (i.e., antibiotic and dressing orders). At that time, the individual had trace edema of his left toes with an ulcer described as having a yellow center and foul odor. On Monday, 8/14/17, his PCP saw him. On that date, the wound care nurse also saw him. The PCP ordered pain medication on a pro re nata (PRN, or "as needed") basis. The second toe also had a callous formation pressure due to his thromboembolic deterrent (TED) hose and shoes. On 8/18/17, he was sent to the ED for evaluation due to worsening cellulitis and worsening blood glucose. Because he was not admitted, he was then provided an intramuscular (IM) antibiotic at Denton SSLC. On 9/21/17, he also was seen in the ED for hypoxia and returned to Denton SSLC.

  A PNMT note, dated 8/22/17, indicated that the "root cause" of the skin integrity issue was not routinely cleaning his feet. He had excessive buildup of medicated powder on his feet leading to increased moisture and lack of space between his toes. Staff were to ensure his toes were dry throughout the day. Direct support professional staff were to complete a daily skin check. He was to change his socks throughout the day, and alternate hosiery to decrease compression of his toes. The PNMT recommended increased use of his wheelchair, with elevation of his legs. The PNMT indicated it would review his skin integrity if not healed in 60 days, or if he developed a new wound, but did not indicate it would consult again sooner if the current wound worsened during that time. The charge nurse and the RN Case Manager (CM) were to increase their monitoring. An ISPA, dated 8/22/17, reflected the intensity of monitoring and implementation of the PNMT's recommendations, along with further recommendations, including no ambulation. Direct support professionals were to check the condition of his skin every shift and after bathing, and urea cream and non-medicated powders were discontinued. Documentation was to be placed in the shift log. On 8/22/17, the PCP ordered consultation with a wound care consultant.

  From 8/26/17 to 9/1/17, Individual #331 was hospitalized due to cellulitis and ulceration of his left 4th toe. He had been given one week of IV antibiotics, and dressing orders had changed. On 9/8/17, a wound consultant saw him and observed he was wearing both TED hose and thick socks. Based on his current orders, he was only to have TED hose. With continued redness and foul odor of the ulcer, on 9/22/17, the wound care consultant saw him and prescribed clindamycin. Local pain increased, and the ulcer enlarged.

On 10/3/17, he transferred to the Infirmary for increased monitoring and treatment of his blood glucose, and to receive IV fluids. On 10/4/17, he returned home. On 10/9/17, the wound care consultant saw him, and indicated there was bone visible at the base of the ulcer. On 10/4/17, 10/5/17, and on 10/10/17, the PCP saw him. On 10/18/17, an x-ray indicated no osteomyelitis. On 11/1/17, he was hospitalized for bilateral pneumonia. During this time, his left fourth toe was observed to have bone necrosis and osteomyelitis. He then underwent amputation of his left 4th toe. He returned to Denton SSLC for post-pneumonia and post-amputation care. A PT note, dated 11/20/17, indicated that the "caseload PT, PNMT PT, floor nurse or charge nurse had not seen the wound since amputation," with progress of healing difficult to determine due to lack of baseline documentation. However, by 11/28/17, there was no need for further dressing, and his break in skin integrity had resolved. A healing ointment was to be applied to strengthen the incision site, and long compression socks were recommended.

This case reflects the need for improved training of home staff, especially nursing staff, on the need to notify the PCPs of skin breakdown in people with diabetes. From the documentation, there appeared to be a four-day delay between identification of a foot ulcer and notifying the PCP as well as the wound care nurse. The on-call PCP was notified, when earlier notification of the home PCP and wound nurse might have resulted in prompt care.

Although the PCP communicated with the ED, there was no continuity of care between Denton SSLC and the medical team/hospitalist team at the hospital. Although a bone scan might have identified osteomyelitis at an earlier time in his prolonged treatment, a bone scan was not completed. The PCP indicated that during the ED visits, Denton SSLC staff requested a bone scan, because it could be promptly scheduled and completed at the hospital, but once Individual #331 returned to the Center, it would take three to four weeks to obtain, delaying aggressive and timely evaluation and treatment. However, the clinical course encompassed about three and a half months, indicating that Denton SSLC could have pursued the bone scan. Improved administrative communication and protocol development between institutions might be needed. In addition, the PCP was not aware of the individual's poor feet hygiene, as the PCP reportedly was called only when a problem needed medical treatment. It was unclear whether the PCP had not attended meetings, or read notes, or if the IDT/PNMT had not communicated well with the PCP. However, a more detailed daily report for the home or at the morning meeting might improve basic communication concerning these issues.

During the on-site visit, the Monitoring Team requested information regarding the level of staff training in the home. The PNMP did list signs and symptoms of diabetic foot care, which directed direct support professionals to inform the nurse if symptoms occurred. Care Tracker also included several instructions for direct support professionals about various aspects of diabetic care. However, it was not clear that this training was competency-based to ensure staff's understanding of this crucial information. No information was provided to show that nursing staff participated in focused or refresher training on diabetes mellitus. In this case, nurses appeared to be responsible for an initial delay in seeking medical team evaluation and treatment of the foot ulcer. Further lapses in communication between disciplines appeared to contribute to

additional potential delays in evaluation and/or treatment and the eventual diagnosis of bone necrosis and osteomyelitis, leading to amputation of the individual's toe.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. However, documentation was generally found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs/ISPs. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	83% 10/12	N/A	1/2	2/2	N/A	1/1	2/2	2/2	1/1	1/2
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed generally were implemented.											

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant and achievable dental outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A
c.	Monthly progress reports include specific data reflective of	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A

	the measurable goal(s)/objective(s);	0/8									
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A

Comments: a. and b. Individual #157's IDT had rated him at low risk for dental, but he had fair oral hygiene, so the IDT should have rated him at least at medium risk, and developed an IHCP to address his dental needs. Individual #331 was edentulous, but was part of the core group, so a full review was conducted.

None of the individuals reviewed had clinically relevant, achievable, and measurable goals/objectives related to their dental risk.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, integrated progress reports on existing goals with data and analysis of the data often were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For all nine individuals, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services.

Outcome 4 – Individuals maintain optimal oral hygiene.

Summary: N/A			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	Not rated (N/R)									

Comments: c. As indicated in the dental audit tool, this indicator will only be scored for individuals residing at Centers at which inter-rater reliability with the State Office definitions of good/fair/poor oral hygiene has been established/confirmed. If inter-rater reliability has not been established, it will be marked "N/R." At the time of the review, State Office had not yet developed and implemented a process to ensure inter-rater reliability with the Centers.

Outcome 5 – Individuals receive necessary dental treatment.

Summary: Given that over the last two reviews and during this review, individuals reviewed had timely restorative work (Round 11 – 100%, Round 12 – 100%, and Round 13 - 100%), Indicator e will move to the category requiring less oversight. It also was positive that individuals	Individuals:

reviewed, for whom it was applicable, received prophylactic care twice a year, the individuals or staff received tooth-brushing instruction twice a year, and those that needed extractions had them only when restorative options were exhausted. The Center should focus on ensuring that individuals with medium or high caries risk ratings receive two fluoride applications per year.											
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	N/A
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	Due to the Center's sustained performance, this indicator was moved to the category requiring less oversight.									
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	57% 4/7	1/1	0/1	0/1	1/1	1/1	1/1	0/1	N/A	
e.	If the individual has need for restorative work, it is completed in a timely manner.	100% 2/2	N/A	N/A	1/1	N/A	N/A	1/1	N/A	N/A	
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 3/3	N/A	N/A	N/A	1/1	1/1	1/1	N/A	N/A	
Comments: a. through f. Individual #331 was edentulous.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	N/A									
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A									

c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A									
Comments: a. through c. Based on the documentation provided, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed experienced dental emergencies in the six months prior to the review.											

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	100% 2/2	N/A	N/A	N/A	1/1	N/A	N/A	1/1	N/A	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/2				0/1			0/1		
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/2				0/1			0/1		
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/2				0/1			0/1		
Comments: a. It was positive that for the two applicable individuals, IDTs defined the frequency of suction tooth brushing in their ISPs/IHCPs. b. Unfortunately, the Center did not submit any data for either individual to substantiate that staff were implementing the suction tooth brushing. c. The Center also did not submit documentation to show that Dental Department staff monitored suction tooth brushing for these individuals in their homes, and documented the findings from their observations. d. For the two individuals, QIDP integrated reviews did not include suction tooth brushing data or analysis of data. Although Individual #435's QIDP included data on a SAP for her to open her mouth during tooth brushing, the QIDP did not discuss data related to the frequency of the completion of suction tooth brushing.											

Outcome 9 – Individuals who need them have dentures.	
Summary: Over this review and the last one, improvement was noted	Individuals:

with regard to the Dentist's assessment of individuals with missing teeth for dentures, and the provision of clinically justified recommendations. If the Center sustains this progress, at the time of the next review, Indicator a might move to the category requiring less oversight.											
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	100% 7/7	N/A	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. It was positive that for the individuals reviewed with missing teeth, the Dentist provided clinically justified recommendations regarding dentures.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0%									
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	0%									

c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0%									
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0%									
e.	The individual has an acute care plan that meets his/her needs.	0%									
f.	The individual's acute care plan is implemented.	0%									

Comments: a. through f. Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. At least in part, the conversion to the IRIS system complicated entry of acute care plans into the system. However, this is a substantial deviation from standard practice and needs to be corrected.

The Monitoring Team has discussed this issue with State Office. Given that Center staff acknowledged that acute care plans have not been consistently developed and entered into the system, it was decided that the Monitoring Team would not search for needed acute care plans that might not exist. However, as a result of this systems issue, these indicators do not meet criteria. Center staff should continue to work with State Office to correct this issue.

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.

Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	11% 2/18	0/2	0/2	0/2	0/2	1/2	0/2	1/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #157 – weight, and skin integrity; Individual #274 – fractures, and GI problems; Individual #669 – falls, and constipation/bowel obstruction; Individual #86 – UTIs, and skin integrity; Individual #327 – falls, and other: osteoarthritis; Individual #256 – choking, and constipation/bowel obstruction; Individual #435 – skin integrity, and UTIs; Individual #416 – constipation/bowel obstructions, and GI problems; and Individual #331 – falls, and weight).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #327 – falls, and Individual #435 – UTIs.

c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports with data and analysis of the data generally were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provision of nursing supports and services to these nine individuals.

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.

Summary: Given that over the last several review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/10	0/1	0/1	0/1	0/1	0/2	N/A	0/2	0/1	0/1
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).										

Comments: As noted above, the Monitoring Team reviewed a total of 18 specific risk areas for nine individuals, and as available, the IHCPs to address them.

a. and c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, or that nursing interventions were implemented thoroughly.

b. The following provide some examples of IDTs' responses to the need to address individuals' risks:

- Based on the documentation provided, Individual #157's IDT did not hold ISPA meetings to address his recurrent episodes of rashes/hives. He had two adverse drug reactions that reportedly were possibly related to his skin issues. However, he continued to have rashes/hives, and at the time of the Monitoring Team's onsite review, he had hives. Although staff reported that they thought his skin issues might be a reaction to the oil from his electronic cigarettes, no written plan was found outlining what factors the IDT might rule in/out in an effort to find the cause(s). In addition, the IDT did not include action steps in the IHCP to address these skin issues, including but not limited to regular nursing assessments of his skin, especially to assist the team in determining whether or not certain substances had an impact. Even absent a plan, it did not appear nurses had initiated such assessments.
- ISPAs, dated 9/19/17 and 11/2/17, indicated that Individual #274 had vomiting episodes and noted that the "root cause" of his vomiting was overeating, which the IDT believed was behaviorally-related. However, the IDT did not determine the reason he was overeating. The IDT did not present data to show how it identified the "root cause." The ISPAs did not mention that the IDT discussed, for example, his psychotropic medications (some of which can cause increases in appetite), his depression symptoms (which can include a lack of activity and over-eating with weight gain), his GERD that could worsen with his rapid and consistent weight gain, his decrease in smoking (which also can cause an increased appetite and cravings), his rate of eating, the food he was eating, and/or if there was a possibility that he self-induced vomiting after binge eating. Without complete data and a thorough analysis of the data, the etiology of his vomiting remained unclear.
- In the year prior to Individual #669's ISP meeting on 10/5/17, she fell 31 times. The IDT documented no comparison to the previous year. Based on data the Center submitted to the Monitoring Team, between 12/10/17 and 3/3/18, she fell at least eight additional times. It was unclear how many times, if any, she fell between her ISP meeting and 12/10/17. On 8/1/17, 8/15/17, and 10/13/17, Individual #669's IDT held ISPA meetings related to her falls. The "Root Cause Analysis" ("RCA") ISPA, dated 10/13/17, documented that the IDT concluded that "falls were not caused by a medical reason but a combination of both environmental and behavioral (impulsivity/impatience/attention seeking)." However, the following provide examples of problems noted with the IDT's process and conclusions:

- The IDT did not document attempts to explore why in June 2017, Individual #669 only fell once (if data submitted were accurate), as opposed to other months during which she fell four or more times;
- The IDT did not document discussion of changes in Depakote (i.e., an increase from 250 mg twice a day to 500 mg twice a day on 6/15/17), decreases in her sodium levels (i.e., on 6/21/17, 9/14/17, 10/23/17, and 12/12/17). As a result, it was unclear how the IDT ruled out potential medical causes for the falls;
- The ISPA, dated 10/13/17, noted the individual's mother recently died (no date provided), and since this happened, she had less family contact. The IDT noted an increase in falls during this time, attributing the increase to the individual wanting attention. However, the IDT did not put a plan in place to address her grief and provide therapy and support;
- The ISPA, dated 10/13/17, indicated that on 9/14/17, the Pharmacist requested via the QDRR an abdominal waist circumference and a lamotrigine level to monitor for toxicity or drug-to drug interactions. According to the ISPA, these tasks had not been completed as of 10/13/17;
- Although at this meeting, the IDT planned some action steps, such as "the IDT will investigate if there is a correlation with staff working patterns and her falls," documentation submitted did not show evidence of completion of these action steps; and
- The Monitoring Team noted discrepancies in data regarding her falls between documents, making it difficult to determine if her falls were increasing or decreasing.

- Although the ISPAs indicated that Individual #86's IDT met regarding her change of status, including the placement of her tracheostomy, and her recurrent aspiration pneumonias, it did not appear the IDT addressed her recurrent UTIs (i.e., that occurred in June 2017, September 2017, and October 2017). From the brief documentation found in the IRRF, she did not have UTIs during the previous year, and the AMA, dated 6/29/17, indicated she had one UTI in 2013, and one in 2014. Clearly, she was experiencing more UTIs than previously. However, based on the documentation provided, the IDT did not initiate proactive interventions, such as training staff and monitoring her hygiene, or monitoring catheterizations designed to address urinary retention to ensure staff used a sterile technique for the procedure.
- Based on ISPAs the Center provided, Individual #327's IDT met to discuss his falls. Between 10/27/17 and 2/15/18, he fell at least nine times. The following concerns were noted with regard to the IDT's response to this risk:
  - An ISPA, dated 8/9/17, indicated that staff were aware that the bed monitor did not work, since Individual #327 urinated in the bed frequently. It was concerning that staff had not previously reported the problems with the monitor, and that the IDT did not develop and implement a toileting plan to prevent him from urinating in his bed.
  - The ISPA, dated 2/27/18, indicated that at times, he slid to the floor and urinated; waited until the "last minute" to go to the restroom; and became impatient and would not wait for staff to assist him. However, knowing this pattern, again suggested that he needed a toileting program.
  - The ISPA, dated 2/9/18, indicated that staff found him in the wrong wheelchair (i.e., the one that was only supposed to be used at night, and while he was in the workshop), and one of his knee pads was

not in place. This potentially increased his risk for falls and/or injuries from falls.
    - The same ISPA indicated that staff found him without his communication book. Given that the IDT previously indicated, he would slide out of his wheelchair when he needed to use the restroom, it was important for the IDT to work on ways to assist him in communicating the need to go to the bathroom. Based on the documentation submitted, it did not appear Individual #327 had a communication system to allow him to let staff know that he needed timely assistance to the bathroom.
    - The IPNs described a number of falls with multiple injuries and a fracture of his right hand. Clearly, at the time of the Monitoring Team's onsite review, the interventions the IDT had implemented were not effective in preventing further falls.
- Individual #327's IDT identified "Pain" as a risk area, which was appropriate, given his osteoarthritis. However, the documentation submitted did not address the status of this significant health issue. For example, nursing staff had not documented regular pain assessments, and it was unclear how his pain was identified and measured, whether or not he required PRN medications (i.e., how often needed, trends or patterns of pain, or effectiveness of the PRN medication), the effect his recurrent falls had on his pain, and any changes in mobility, activities, mood, or sleep related to pain.
- Based on the changes in health status and decline Individual #435 experienced, the IHCP for skin integrity was not consistent with current nursing guidelines or standards. The ISPAs provided did not address the frequent episodes of emesis she was having, how to prevent further UTIs, or her skin issues.
- On 10/24/17, 12/6/17, and 1/27/18, Individual #416 experienced pneumonia/aspiration pneumonia. The documentation indicated that he was having episodes of emesis. However, in the IRRF or the Nursing Annual/Quarterlies, staff did not document the specific dates on which emesis occurred. Information from the PNMT Assessment, dated 12/6/17, indicated that:
    - On 10/16/17, he vomited. However, other documentation submitted to the Monitoring Team indicated that he also vomited on 11/19/17;
    - On 11/21/17, the PNMT nurse found:
        - Him "lying on his back" at -5 degrees, which was not in alignment with his PMNP that required 15 degrees of elevation;
        - Staff brought the wrong sling to transfer him using the mechanical lift until PNMT nurse intervened;
        - The medication nurse overfilled his nosey cup beyond the limit of half full; and
        - Staff did not offer a few sips of fluid before starting a meal as the PNMP required.

  Clearly, staff were not complying in implementing Individual #416's PNMP, which increased his risk of aspiration pneumonia. In addition, the IDT devoted little attention to his episodes of emesis, which also increased his risk of pneumonia/aspiration pneumonia.
- The ISPAs provided did not address Individual #331's falls, one of which resulted in a fractured left 9th rib in March 2017. Based on documentation the Center provided, since his ISP meeting on 8/23/17, he fell at least five times. The documentation indicated that he had significant issues with frequent hypoglycemia and hyperglycemia. However, the documentation did not show that the IDT conducted an analysis of his

falls in comparison with, for example, blood sugar data.

Outcome 6 – Individuals receive medications prescribed in a safe manner.											
Summary: For the four previous reviews, as well as this review, the Center did well with the indicators related to: 1) nurses administering medications according to the nine rights; and 2) nurses adhering to infection control procedures while administering medications. However, given the importance of these indicators to individuals' health and safety, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will remain in active oversight as well.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R							N/A		
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	100% 2/2	N/A	N/A	N/A	1/1	N/A	1/1	N/A	N/A	N/A
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last	100% 3/3	N/A	N/A	N/A	2/2	N/A	N/A	N/A	1/1	N/A

	review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.										
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	0/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k. y	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of eight individuals, including Individual #157, Individual #274, Individual #669, Individual #86, Individual #327, Individual #256, Individual #416, and Individual #331.											

c. It was positive that for the individuals the Monitoring Team member observed during medication passes, nursing staff followed the nine rights of medication administration.

d. It also was good to see that for the two applicable individuals, IHCPs defined the frequency of respiratory assessments, including lung sound assessments, and nurses implemented them.

e. Although the Monitoring Team could not fully assess Indicator e due to issues with IRIS documentation, during medication observations, the Monitoring Team member observed two medication nurses administer PRN medications. For Individual #157, the medication nurse followed the correct procedures.

For Individual #331, the medication nurse gave the individual Tylenol 650 milligrams (mg) PRN. However, the nurse did not conduct an assessment prior to the administration of the medication. Individual #331 was coughing and complained of a sore throat. The nurse did not conduct an assessment of the individual's throat or use a pain scale. As a result, the nurse did not have objective data with which to determine the effectiveness of the PRN medication.

f. It was positive that for the individuals observed, medication nurses used the individuals' PNMPs and checked the position of the individuals prior to medication administration.

g. For the individuals observed, nursing staff generally followed infection control practices, which was good to see. The exception was that after drawing up insulin and prior to administering it, the nurse for Individual #331 recapped the needle. This practice increases the likelihood of a needle stick, which places the nurse at risk.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Although IDTs continued to improve with regard to referring individuals to the PNMT, when needed, this is an area that requires continued focus. Overall, IDTs and/or the PNMT did not have a way to measure clinically relevant outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall	157	274	669	86	327	256	435	416	331

		Score									
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	0/1	N/A	0/1	0/1	0/1	0/2	N/A	N/A	N/A
	ii. Individual has a measurable goal/objective, including timeframes for completion;	50% 3/6	0/1		1/1	1/1	1/1	0/2			
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	33% 2/6	0/1		1/1	1/1	0/1	0/2			
	iv. Individual has made progress on his/her goal/objective; and	0% 0/6	0/1		0/1	0/1	0/1	0/2			
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/6	0/1		0/1	0/1	0/1	0/2			
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	67% 8/12	1/1	2/2	1/1	1/1	0/1	N/A	0/2	2/2	1/2
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/12	0/1	0/2	0/1	0/1	0/1		0/2	0/2	0/2
	iii. Individual has a measurable goal/objective, including timeframes for completion;	8% 1/12	0/1	0/2	0/1	0/1	0/1		1/2	0/2	0/2
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/12	0/1	0/2	0/1	0/1	0/1		0/2	0/2	0/2
	v. Individual has made progress on his/her goal/objective; and	0% 0/12	0/1	0/2	0/1	0/1	0/1		0/2	0/2	0/2
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/12	0/1	0/2	0/1	0/1	0/1		0/2	0/2	0/2
	Comments: The Monitoring Team reviewed six goals/objectives related to PNM issues that five individuals' IDTs were responsible for developing. These included goals/objectives related to: falls for Individual #157; choking for Individual #669; choking for Individual #86; choking for Individual #327; and aspiration, and choking for Individual #256.										

a.i. through a.iii. None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: choking for Individual #669, choking for Individual #86, and choking for Individual #327. The QIDP integrated reviews for Individual #669 and Individual #86 contained data for these goals/objectives.

b.i. The Monitoring Team reviewed 12 areas of need for eight individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: weight for Individual #157; fractures, and GI problems for Individual #274; falls for Individual #669; aspiration for Individual #86; falls for Individual #327; weight, and aspiration for Individual #435; aspiration, and GI problems for Individual #416; and skin integrity, and aspiration for Individual #331.

These individuals should have been referred or referred sooner to the PNMT:

- Since October 2017, Individual #327 fell at least nine times. The falls were an ongoing issue that continued despite receipt of direct PT therapy to address falls. Based on the documentation provided, the IDT did not refer the individual to the PNMT, and the PNMT did not conduct a review.
- Between March 2017 and her death in December 2017, Individual #435 had multiple issues, including hospitalizations for pneumonia from 2/28/17 to 3/17/17, again from 3/18/17 to 3/23/17, chronic respiratory failure from 3/24/17 to 3/30/17, trouble breathing on 6/22/17, respiratory distress on 9/5/17, and low oxygen saturation levels on 9/14/17. Additionally, on 3/31/17, undesired weight gain was noted. The PNMT conducted a review of her weight, and then another review on pneumonia, but never conducted an assessment that addressed all of her PNM-related issues.
- On 8/21/17, Individual #331 experienced altered respiratory status. On 9/3/17, he had low oxygen saturation levels, and again, in 10/21/17, he had pneumonia with no evidence of PNMT discussion. The first PNMT review regarding pneumonia was not completed until 12/11/17, in response to a diagnosis of pneumonia on 12/9/17. The PNMT made no recommendations beyond having nursing staff monitor his lung sounds for 30 days. During this time, Center staff changed his liquid consistency back to thin from the nectar-thick liquids the hospital staff recommended. On 2/7/18, in response to another pneumonia, the PNMT conducted another review.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT did not develop clinically relevant, achievable, and measurable goals/objectives for these individuals. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: aspiration for Individual #435.

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of measurable goals/objectives, integrated progress reports with data and analysis of the data generally were not available to IDTs. As a result of the lack of

data, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure clinically relevant outcomes for individuals, the Monitoring Team conducted full reviews of all nine individuals' PNM supports.

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	11% 2/18	0/2	1/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	36% 4/11	0/1	1/2	0/1	0/1	N/A	N/A	0/2	2/2	1/2
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	67% 6/9	0/1	N/A	0/1	0/1	N/A	N/A	2/2	2/2	2/2

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, the IHCPs for which the QIDP interim reviews included documentation to confirm the implementation of the PNM action steps were for GI problems for Individual #274, and falls for Individual #669.

b. The following provide examples of findings related to IDTs' responses to changes in individuals' PNM status:

- Beginning in December 2016, Individual #157's weight had been trending down, but evidence was not found of IDT discussion to develop a plan to address the etiology(ies) of his weight loss.
- Between May 2017 and July 2017, Individual #669 experienced 12 falls, but the IDT did not put plans in place to effectively address them, and did not refer her to the PNMT until August 2017. Between August 2017 and September 2017, Individual #669 fell 10 times.

c. ISPAs for three individuals showed thorough discharge planning between the PNMT and their IDTs. Examples of concerns, though, included:

- On 9/18/17, the PNMT conducted a review of Individual #157, but the Center did not submit evidence to show the IDT held an ISPA meeting to discuss discharge from the PNMT.
- Although the PNMT identified a need for improved data collection related to Individual #669's falls (i.e., actual falls versus the individual sitting down), documentation was not found to show the PNMT held a

meeting with the IDT to formalize action steps to collect and analyze such data.
- Individual #86 experienced multiple changes of status, but without a comprehensive assessment, the PNMT and IDT did not have sufficient information with which to develop a meaningful discharge plan.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: During numerous observations, staff failed to implement individuals' PNMPs as written. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them. These indicators will remain in active oversight.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	30% 13/43	
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	0% 0/3	
Comments: a. The Monitoring Team conducted 43 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during seven out of 16 observations (44%). Staff followed individuals' dining plans during six out of 25 mealtime observations (24%). Staff completed transfers correctly during zero out of two observations (0%).			

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an	0% 0/2				0/1			0/1		

	individual's progress along the continuum to oral intake are implemented.										
Comments: a. The IDTs for Individual #86 and Individual #435 had not developed measurable plans, or justified not doing so.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: It was good to see that a number of OT/PT goals/objectives developed for individuals reviewed were clinically relevant, and measurable. However, sometimes, IDTs did not incorporate them into ISPs/ISPAs. In addition, QIDP interim reviews often did not include data and analyses of data related to these goals/objectives, and at times, therapists did not provide monthly summaries for QIDPs' use. As a result, IDTs did not have information in an integrated format related to individuals' progress or lack thereof. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	60% 6/10	1/1	1/1	1/1	1/1	2/2	0/1	0/1	N/A	0/2
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	40% 4/10	0/1	1/1	0/1	1/1	2/2	0/1	0/1		0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/10	0/1	0/1	0/1	0/1	0/2	0/1	0/1		0/2
d.	Individual has made progress on his/her OT/PT goal.	0% 0/10	0/1	0/1	0/1	0/1	0/2	0/1	0/1		0/2
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/10	0/1	0/1	0/1	0/1	0/2	0/1	0/1		0/2
Comments: a. and b. The goals/objectives that were clinically relevant and achievable, as well as measurable were those for Individual #157's goal/objective related to increased range of motion without pain, Individual #274											

related to range of motion of his left elbow, Individual #86 related to passive range of motion to bilateral shoulders, and Individual #327 related to transfers, and improving his upright static stance.

Although Individual #331's goals objectives related to ambulating 75 feet, and sitting upright were clinically relevant and measurable, the IDT had not reviewed, and approved them, and incorporated them into the ISP or an ISPA.

Individual #416's OT/PT needs were addressed informally through positioning plans and the PNMP, so he did not require a goal/objective.

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, integrated progress reports with data and analysis of the data generally were not available to IDTs. Problems contributing to the lack of integrated progress reports varied. For example, for some individuals, therapists appeared to have collected data on the provision of direct therapy, but QIDPs did not include data and analysis of data in reports (e.g., Individual #274, Individual #86, Individual #327, and Individual #331 for ambulation); and at times, OT/PT's treatment notes did not reflect measurable data on the stated goals/objectives (e.g., Individual #669, and Individual #331 for sitting upright).

As a result of these various issues, IDTs did not have complete, and integrated data with which to make decisions. Overall, it was difficult to determine through review of the ISP integrated, and at times, through review of the direct therapy notes whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. The Monitoring Team conducted full reviews for all nine individuals.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	55% 6/11	0/1	1/1	0/1	1/1	2/2	0/1	0/1	0/1	2/2
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	75% 3/4	1/1	0/1	1/1	N/A	1/1	N/A	N/A	N/A	N/A
Comments: a. For approximately half of the OT/PT action plans/supports reviewed, the Center did not submit data to show they were implemented as written.											

b. Individual #274's IDT held a meeting to discuss his discharge from direct therapy. However, the IDT did not document that it discussed the reason for his discharge (i.e., his lack of participation), and its impact on his range of motion.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: It was good to see that for all but one of the 29 individuals observed, their adaptive equipment appeared to fit. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals, this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	666	173	21	50	687	660	608	157	478
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance, these indicators were moved to the category requiring less oversight.									
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.										
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	97% 28/29	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		214	284	738	669	38	45	373	91	271
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	2/2	1/1	1/1	0/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		707	619	339	308	498	362	713	83	608

c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		250								
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1								

Comments: a. At the time of the last review, although Indicator a was in less oversight, for approximately 15% of the adaptive equipment observed, a lack of cleanliness was a problem. However, during this review, the Center appeared to have addressed the problem, and all adaptive equipment the Monitoring Team member observed was clean.

c. Based on observation of Individual #45 in her wheelchair, she was not positioned correctly, and continued to slide down in the chair. It is the Center's responsibility to determine whether or not this issue was due to the equipment, or the staff not positioning individual correctly, or other factors.

Domain #4: Individuals in the Target Population will engage in meaningful activities, through participation in active treatment, community activities, work and/or educational opportunities, and social relationships consistent with their individual support plan.

This domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition, dental refusals, and communication. At the time of the last review, none of the indicators had sustained high performance scores sufficient to be moved the category of less oversight. Presently, two indicators in the area of skill acquisition will move to the category of less oversight.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

In the ISPs, even though 16 (of 36 possible) goal areas had personal goals that met criterion, data were not available and, therefore, progress could not be determined. Moreover, action plans were not consistently implemented for any individuals.

Skill acquisition plans did not have reliable data so that progress could be determined. SAPs continued to contain some, but not all, of the required components. Most SAPs (five of six) observed by the Monitoring Team were not implemented correctly.

The greenhouse and ceramics program offer opportunities for work outside of the usual workshop environments. The ceramics program includes opportunities for displaying and selling products at a downtown store and at local festivals. The computer lab was quite busy when observed. Each individual was actively engaged, exploring areas of his or her interest.

Denton SSLC regularly measured engagement and set goal engagement scores. Meeting these goals and supporting individuals to be engaged throughout the day remain important goals for the Center (i.e., they were not yet being met). During the onsite week, about one-third of the individuals were meaningfully engaged most of the time.

For applicable individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals, and had not developed plans to address the refusals.

It was concerning that often individuals' alternative and augmentative (AAC) devices were not present or readily accessible, and that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them. The Center should focus on improvements in these areas.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Even though 16 (of 36 possible) goal areas had personal goals that met criterion with indicator 1, data need to be available (indicator 3) in order for progress to be determined. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	157	173	274	543	669	327			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments: As Denton SSLC further develops individualized personal goals, it should focus on developing actions plans that clearly support the achievement of those personal goals, and thus, the facility can achieve compliance with this outcome and its indicators.

4-7. A personal goal that meets criterion for Indicators 1 through 3 is a pre-requisite for evaluating whether progress has been made. For these six individuals, there was no basis for assessing progress as the IDTs failed to develop any personal goals that were also measurable and had reliable and valid data. The Monitoring Team found the lack consistent implementation to be significant concerns.

Outcome 8 – ISPs are implemented correctly and as often as required.

Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	157	173	274	543	669	327			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
39. The Monitoring Team's evaluation of this indicator is based on observations, interviews, and review of documentation that reflects implementation. Overall, none of six ISPs had documentation that reflected consistent implementation. In addition, staff lacked knowledge of how and when to implement action plans, which again may have been attributable to the Center's reliance on SOs that had no clear implementation plans.

40. Action steps were not consistently implemented for any individuals, as documented elsewhere in this section and throughout this report.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: SAPs did not have reliable data so that progress could be determined. Performance regarding the updating of goals and plans remained about the same or lower than at the last review. These four indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
6	The individual is progressing on his/her SAPS	6% 1/16	N/A	0/2	N/A	1/3	N/A	0/2	0/3	0/3	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	20% 1/5	N/A	N/A	N/A	0/2	N/A	N/A	1/1	0/2	N/A
9	Decisions to continue, discontinue, or modify SAPs were data based.	69% 9/13	N/A	2/2	N/A	0/2	N/A	N/A	3/3	1/3	3/3

Comments:
6. Based upon a review of the Center's data presented in the text of the QIDP Monthly Reports and graphically in the Client SAP Training Progress Note, it was determined that progress was being made in 11 of the 16 SAPs. However, this indicator is rated as zero for all due to problems with the reliability of the data. (Note that 11 SAPs were excluded from this analysis because they had just recently been introduced.) Although data were reported on step 1 only, it was evident when observing the SAP for Individual #157 (clean up work area), that he had learned this skill.

7. The SAP objective was not met in any of the objectives.

8. Of the five SAPs in which it could be determined that progress was not being made based upon Center data, there was evidence of action taken for one: the QIDP for Individual #274 indicated he would explore the implementation of a greater number of trials.

No action was taken to address the lack of progress for Individual #157 learning to cook or for Individual #543 learning to wash his hands or turn on a CD player. There appeared to be no action taken to address Individual #157's shaving SAP after he reported that he preferred having facial hair during the winter months.

Outcome 4- All individuals have SAPs that contain the required components.

Summary: SAPs continued to contain some, but not all, of the required components. Some detailed feedback is provided in the comments below. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
13	The individual's SAPs are complete.	0% 0/27	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3

Comments:
13. None of the 27 SAPs were considered complete. However, in the majority of SAPs, the following components were evident: task analysis where appropriate, behavioral objective, operational definitions, relevant discriminative stimulus, consequences for incorrect responding, and documentation methodology.

Missing were instructions specific to the task, a teaching schedule that clearly included the number of trials to be conducted during identified days of instruction, and consequences for correct responding that were individualized beyond solely the use of praise.

Specific feedback is provided below.

- Although all SAPs included behavioral objectives, several objectives indicated the individual would display the skill with the same prompt as indicated in his or her reported current level of performance. This included Individual #157 (cook tacos), Individual #173 (set up snack), and Individual #543 (use a CD player). The prompt level was more intrusive in the objective addressing Individual #274's writing his grandmother's address.
- While most SAPs referenced the identified skill in the operational definition, several referenced other skills (e.g., Individual #115's setting up her work area in ceramics referenced her sorting files, Individual #157's washing hands SAP included a description of shaving, Individual #173's brushing teeth SAP referenced his inserting a coin in a machine).
- In two of the SAPs for Individual #543 (wash hands and play CD), instructions were somewhat inconsistent. Staff were advised to use minimal physical prompting and avoid over prompting, yet they were also advised to use full assistance to have him complete all steps in the task analysis.
- Praise was the consequence for correct responding in most SAPs. As has been noted previously, for praise to serve as a reinforcer it is often dependent on the relationship between the individual and the person delivering the praise. Further, staff should always consider the age and abilities of the individual when delivering praise. For example, staff were advised to say, "Yay, you did it," when Individual #274 completed his SAPs. These comments are better reserved for a young child rather than a young man with good cognitive abilities and a wide array of independent and age appropriate skills.
- Maintenance and generalization planning did not always reference the identified skill. For example, plans for generalization in all three of Individual #157's SAPs (clean work area, cook lunch, and shaving) and two of Individual #274's SAPs (write grandmother's address and complete an application) noted that they could use the skill after using the toilet and before eating snack.

Outcome 5- SAPs are implemented with integrity.

Summary: A lot of work goes into choosing SAPs (though more meaningful, practical, and functional SAPs need to be chosen), writing the plans, and then trying to get them implemented. Given all that work, correct implementation is essential if all of this is not to be for naught. Indicator 15, regarding checking SAP implementation integrity improved ever so slightly (to 7%) from 0% during the last three reviews. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
14	SAPs are implemented as written.	17% 1/6	0/1	N/A	N/A	1/1	0/1	0/1	N/A	0/1	0/1

15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	7% 2/27	0/3	1/3	0/3	0/3	0/3	0/3	0/3	1/3	0/3

Comments:
14. The Monitoring Team was able to observe the implementation of one SAP for each of six individuals. The exceptions were Individual #227 and Individual #96 who were not at workshop at the scheduled time of observation, and Individual #274 who indicated that he did not want to complete the SAP.

Individual #157's SAP was implemented correctly. When he was observed cleaning his work area, it was very clear that he had learned this skill. As discussed with the BCBA who helped to oversee SAP development and implementation, it would be advisable to periodically assess whether the individual can perform the terminal objective. If he or she consistently displays skill acquisition, plans should be put in place to help him or her maintain and generalize the skill, while revising or replacing the SAP to ensure continued learning.

For the remaining five individuals, there were observed problems with SAP implementation.

- Individual #115 - She was observed setting up her work area in the ceramics program. The SAP noted that materials should be readied and in their appropriate area, but this was not evident. The staff member told her each step to complete, which she did readily. It would appear that a simple checklist could be used by Individual #115 to help her become more independent in this area.
- Individual #159 - She was working on identifying coins. The SAP indicated that she should label coins as they were presented. When this SAP was implemented, she was asked to point to coins named by the staff member. She was able to do this fairly well and continued to count by tens, and state how many quarters made one dollar. It is recommended that her performance on the terminal objective be probed.
- Individual #173 - His SAP indicated that he would work on setting up his snack in the break room of the gym because this was a quieter environment that would contain fewer distractions while providing privacy. This SAP was implemented at the Wooden Nickel during a time of day when many other people were present.
- Individual #543 - When the SAP was implemented, he held on to a preferred object (Tangle) the entire time, making it difficult for him to wash his hands.
- Individual #25 - He did not complete the hand washing routine during this observation. Staff used repeated verbal prompts rather than initiating the correction procedure.

Although Individual #274 indicated he did not want to complete his SAP, several suggestions were discussed with the individual, his assigned staff person, and the BCBA who oversaw SAP development and implementation. Individual #274 had memorized his grandmother's address, but required a written model. It would be appropriate for this to be provided to him when he completed this SAP rather than having staff spell out the information or use hand over hand prompting to ensure his success. Further, he knew how to use voice to text applications. It may be more meaningful for him to write a letter to his grandmother, address the envelope, and then travel to the local post office to mail this correspondence.

15. The facility had a policy that indicated each SAP will be assessed at a minimum of once every six months. The identified minimum level of correct implementation was 80%. If this was not achieved, feedback and retraining were to be provided. Of the 27 SAPs that were reviewed, two had evidence of treatment integrity over the previous six-month period. These were the SAP for Individual #227 to clean her workspace and the SAP for Individual #543 to wash his hands.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.

Summary: Performance was about the same as at the last review. Monthly reviews and useful graphic summaries will be important for those who are responsible for reviewing and updating SAPs. Note the comment below regarding staff recording SAP data without having implemented the plan. These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
16	There is evidence that SAPs are reviewed monthly.	46% 11/24	0/3	0/3	1/3	3/3	N/A	1/3	0/3	3/3	3/3
17	SAP outcomes are graphed.	60% 12/20	0/2	2/2	1/1	2/3	N/A	3/3	2/3	1/3	1/3

Comments:

16. There was evidence that 11 of 24 SAPs had been reviewed monthly since they were first introduced. Individual #159's three SAPs were excluded from this analysis because they had just been introduced in March 2018.

Problems included reports repeated each month that SAPs had not yet been implemented (e.g., Individual #115 - all SAPs, Individual #227 - writing name, and Individual #96 - all SAPs), and/or data that varied from month to month, making it difficult to interpret progress (e.g., Individual #173 - brushing teeth and stop at curb).

It was noted in the monthly report for both Individual #543 and Individual #25 that staff were entering data into Care Tracker without running the SAP.

17. Graphs were available for 20 SAPs and 12 of these were rated in compliance with this indicator. Exceptions were graphs in which data were not consistently depicted (e.g., Individual #115 - sort alphabetically and SAMS), and graphs in which step changes were not indicated (e.g., Individual #543 - wash hands and pay for food, and Individual #25 - wash hands and use DVD player).

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.

Summary: Denton SSLC regularly measured engagement and set goal engagement scores. This has been the case for the past two reviews and, therefore, indicators 19 and 20 will be moved to the category of requiring less oversight. Meeting these goals and supporting individuals to be engaged throughout the day remain important goals for the Center. Therefore, indicators 18 and 21 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	227	96	157	159	173	274	543	25
18	The individual is meaningfully engaged in residential and treatment sites.	33% 3/9	1/1	0/1	0/1	1/1	1/1	0/1	0/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

18. Based on observations conducted the week of the onsite visit by the Monitoring Team, it was determined that three of the nine individuals were meaningfully engaged most of the time. These were Individual #115, Individual #157, and Individual #159.

For all others, repeated observations indicated the individual spent a good amount of time wandering around campus (Individual #227 and Individual #96), engaged in non-functional, stereotypical activity (Individual #173 and Individual #543), in his room (Individual #274), or unengaged (Individual #25).

19-20. The facility had a policy to assess engagement on all residential and day program sites once each month. Engagement goal levels were established at 65%.

In the future, it would be helpful for the facility to report assessment frequency and goal levels for individual homes and day program sites.

21. For all nine individuals, the assessment frequency and/or goal levels were not met over a six-month period. Engagement was assessed each month over a six-month period in the homes of Individual #115, Individual #157, and Individual #173. For all others, engagement was assessed four to five times during this same period of time.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: These indicators were not met, indicating that more attention needs to be paid to individuals having opportunities for community outings and for training and learning of new skills in the community. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	227	96	157	159	173	274	543	25
22	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: 22. None of the nine individuals met their goal frequencies for community-based recreational activities. 23. There was no evidence of SAP training in the community for any of the nine individuals. 24. There was no evidence that the IDT for each of the nine individuals had met to discuss barriers to community recreational activities or community-based SAP training.											

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
Summary: The Monitoring Team now has the same feedback for the Center for the third consecutive time. That is, that it was good to see that IDTs were somewhat involved with individuals' school programs, but that the Center needed to show that the IDT participated in the IEP and developed action plans in the ISP to support individuals' IEPs. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	468								
25	The student receives educational services that are integrated with the ISP.	0% 0/1	0/1								

Comments:
25. None of the nine individuals in the review group were attending school, so a review was completed of the educational services provided to Individual #468. There was public school-related information in is ISP along with action plans that supported his IEP. As evidenced in his IEP, inclusion and an extended school year were considered. All of this was very good to see.

However, due to a scheduling conflict, the QIDP had not participated in the IEP process and there was no evidence that an alternative staff member had attended his meeting. Further, there was no evidence that the IDT had reviewed his school progress.

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant and achievable outcomes related to dental refusals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/3	N/A	0/1	0/1	N/A	N/A	0/1	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/3		0/1	0/1			0/1			
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/3		0/1	0/1			0/1			
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/3		0/1	0/1			0/1			
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/3		0/1	0/1			0/1			
Comments: a. through e. Individual #274 had three documented refusals, Individual #669 had two, and Individual #256 refused to enter the Dental Clinic. Based on documentation provided, none of the IDTs for the three individuals had developed a plan to address the refusals.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Overall, IDTs did not have a way to measure clinically relevant, achievable, and measurable outcomes related to individuals' formal communication services and supports. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	157	274	669	86	327	256	435	416	331
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: a. and b. Although Individual #157 had functional expressive and receptive communication skills, his assessment identified higher level skills, such as articulation and problem-solving, in which he had deficits. Given that his stated goal was to live in an apartment near his mother, he would have benefitted from more complex skill development. Similar concerns were noted for Individual #274, Individual #669, and Individual #331. The goal/objective that was clinically relevant, but not measurable was Individual #327's goal/objective related to identifying the icons on his AAC device. c. through e. The Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives.											

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall	157	274	669	86	327	256	435	416	331

		Score									
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
Comments: a. For Individual #327, the goal/objective often was not implemented due to the device being broken. The IDT should have met to revise the goal/objective making use of a supporting device until repairs could be made. Instead, the IDT met, and terminated the goal/objective and based this termination on the individual's lack of desire to use the device.											

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.											
Summary: The Center should focus on ensuring individuals have their AAC devices with them, and that staff prompt individuals to use them in a functional manner. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	666	372	327	440	757	151			
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	33% 2/6	1/1	0/1	0/1	0/1	1/1	0/1			
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	0% 0/3									
Comments: a. and b. It was concerning that often individuals' AAC devices often were not present or readily accessible, and/or that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them.											

Domain #5: Individuals in the Target Population who are appropriate for and do not oppose transition to the community will receive transition planning, transition services, and will transition to the most integrated setting(s) to meet their appropriately identified needs, consistent with their informed choice.

This Domain contains five outcomes and 20 underlying indicators. At this time, two indicators will move to the category requiring less oversight.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

Although not yet at criteria, the Center made good progress on identifying the measurable criteria upon which the Post-Move Monitor can accurately judge implementation of each support. Although a number of essential supports were missing from the Community Living Discharge Plans (CLDPs) reviewed, since the last review, the Center made substantial progress. Center staff are encouraged to continue making improvements in these areas.

It was positive that the Post-Move Monitor (PMM) conducted timely monitoring for the individuals reviewed. Due to consistent positive findings with regard to timeliness, the related indicator will move to less oversight. Although the PMM generally paid good attention to detail, some of the areas in which continued efforts were needed related to the PMM consistently basing decisions about supports on reliable and valid data, the PMM correctly scoring the presence or absence supports based on the evidence, and developing a process to ensure that IDTs follow up in a timely and thorough manner when the PMM notes problems with the provision of supports.

Neither individual experienced a potentially disrupted community transition (PDCT) event.

Due to consistent positive findings with regard to IDT members actively participating in the transition planning process, the CLDPs specifying the staff responsible and timeframes for transition actions, and IDTs reviewing the CLDPs with the individual and, as appropriate, the LAR, to facilitate their decision-making, the related indicator will move to the category requiring less oversight.

It was positive transition staff worked with several disciplines on the quality of transition assessments and recommendations. Some progress was observed, but additional improvement was needed in the completion of all needed assessments, as well as the inclusion of comprehensive and community-appropriate recommendations. Although Center staff provided training to community provider staff, the CLDPs did not

define the training thoroughly, and Center staff still were not able to confirm that community provider staff were competent to meet individuals' needs at the time of transition.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.												
Summary: Although not yet at criteria, the Center made good progress on identifying the measurable criteria upon which the Post-Move Monitor can accurately judge implementation of each support. Although a number of essential supports were missing from the CLDPs reviewed, since the last review, the Center had made substantial progress. Center staff are encouraged to continue making improvements in these areas. These indicators will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	230	720								
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1								
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1								

Comments: Since the Monitoring Team's last visit, three individuals transitioned from the Center to the community. Two were included in this review (i.e., Individual #230, Individual #720). Both individuals transitioned to community homes operated under the State's Home and Community-based Services (HCS) program. The Monitoring Team reviewed these two transitions and discussed them in detail with the Denton SSLC Admissions and Placement staff. The transition team was clearly invested in continuing to make improvements.

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how individuals' needs and preferences will be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. Denton SSLC had made good progress in this area. To move toward compliance, the IDTs should continue to focus on identifying the measurable criteria upon which the PMM can accurately judge implementation of each support. Examples of supports that both met and did not meet criterion are described below:

- Pre-move supports: The respective IDTs developed 13 pre-move supports for Individual #230, and 16 pre-move supports for Individual #720.
  - For Individual #230, nine of the pre-move supports focused on providing equipment and needed materials/documents (such as behavioral data collection sheets, sample menus, and a State of Texas

ID), as well as addressing environmental concerns, such as installing grab bars in the tub/shower. These met criterion for measurability.

- For Individual #720, nine pre-move supports also addressed providing equipment (such as bed risers and a bed monitor) and needed materials/documents (such as behavioral data collection sheets, ordering information for his shoes, and a State of Texas ID.) These met criterion for measurability.
- Individual #720's CLDP included a requirement for the provider to have a pica protocol in place prior to the move, but did not provide measurable criteria for evaluating whether it was adequate to meet his needs.
- Overall, the Center had made good progress in developing measurable supports for pre-move training for these individuals. To meet criterion, pre-move training supports should address the content of provider staff training as well as describe the staff to be trained, the training methodologies to be used, the competency criteria, and how competency will be measured. The Center should continue to focus on defining specific competency criteria and ensuring the tools for measuring those competencies are thorough. Findings included:
    - For Individual #230, only one of three pre-move training supports, for current nursing problems, described the provider staff who needed to be trained. For Individual #720, the CLDP indicated Denton SSLC would train the provider home director/ RN for all areas. His CLDP did not specify how provider direct support staff would be trained.
    - For both individuals, all supports provided a list of topics as the content to be covered under each broad area of training. Some went further and indicated the specific knowledge provider staff would be required to know by the time of the transition, which was positive. These included the behavioral training support for Individual #230, and each of Individual #720's supports. Some, such as Individual #230's pre-move training supports for nursing and habilitation needs, did not provide specific criteria by which competency could be measured.
    - For both individuals, a pre-move support indicated the Center's Registered Nurse (RN) or designee was to provide in-service on medical diagnoses and medications only to the provider RN. The Center did not provide evidence of any testing material for these supports, but rather provided a progress note from the Center RN attesting to the belief that all nursing services and safety precautions could and would be provided as required. This did not meet criterion for measurability. In addition, the supports did not describe a methodology for measuring the knowledge of other staff.
    - Few of the pre-move in-service supports referenced methodologies for training. The IDT should specify the type of training methodology for each support depending on the need. For example, some supports for use of adaptive equipment might be best taught through demonstration. It was positive that one support for Individual #720 did call for the provider to demonstrate how to use a food processor to create the needed ground texture and how to use powder or gel to thicken liquids. The support did not state how the training for this would be provided.

- Overall, supports did not reference how provider staff competency would be determined. As described above, it was positive the IDT for Individual #720 required the provider to demonstrate how to use a food processor and how to thicken liquids. Otherwise, the only other support that referenced competency demonstration was the behavioral training support for Individual #720, and it only indicated a test would be included.

- Post-Move: The respective IDTs developed 63 post-move supports for Individual #230, and 46 post-move supports for Individual #720. Many post-move supports for both individuals were measurable. The Monitoring Team observed progress in this area, but this was not yet consistent. Concerns included:
  - For both individuals, the IDT developed some supports that did not make clear whether certain activities were required or optional. For example:
    - The IDT developed a single support for Individual #230 to be provided with weekly opportunities to increase her independence, citing five possible options. The IDT used the wording "such as, but not limited to" to describe these opportunities. This left the expectation broad and open to interpretation.
    - Individual #720 had a similarly constructed support for increasing independence. He also had a support for opportunities to participate in social activities of his preference, "such as" a list of 13 options. These included several activities that were particularly important to him, including dancing and t-ball. Still, due to its broad wording, the support could have been met simply by taking van rides and playing Connect 4.
  - For Individual #230, the CLDP included a support for the provider to assist her to attain several goals, one of which included finding employment in the community. This support did not provide any measurable expectations about outcomes, timelines, or specific detail about how the provider would provide this assistance.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for this indicator to meet criterion. The Center identified many supports for these two individuals and it was positive they had made a diligent effort to address their needs. This represented substantial improvement. Still, neither of these CLDPs fully and comprehensively addressed support needs and did not meet criterion, as described below.

- Past history, and recent and current behavioral and psychiatric problems: To meet criterion, CLDPs needed to include comprehensive supports that address behavioral and psychiatric history, including how the provider could recognize re-emerging concerns and address them proactively. For both individuals, the IDT developed some very detailed pre- and post-move supports related to current behavioral needs as well as pertinent history. This was positive, but not yet consistent. For example, as described above, Individual #720's CLDP included a support for the provider to develop a pica protocol, but did not provide any criterion to evaluate whether the protocol was adequate to meet his needs. For Individual #230, the psychiatry assessment indicated if she experienced a sudden change in behavior that the home staff are not able to manage, the psychologist/behavior analyst, nurse, and the PCP should be consulted before considering major changes in psychotropic medications. The CLDP did not include this recommendation in the supports.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: As described in the previous site visit report, the Center continued to use a standardized core set of supports for inclusion in all CLDPs (such as a bowel management plan) as a means of ensuring many needs were addressed. The Monitoring Team noted the IDTs needed to ensure these core supports were individualized as needed. To meet criteria, the IDTs still needed to focus on developing individualized, clear, and comprehensive supports in this area. Examples of supports that met criterion and those that did not included:
    - As indicated above and consistent with findings from the previous site visit, pre-move training supports did not clarify that direct support staff needed training to a specific level of competency for medical, healthcare, therapeutic, and risk needs. Post-move supports often identified actions staff were to take in these areas, but no pre-move verification of training, knowledge, or competency had been required. It is incumbent on the IDTs to verify staff have knowledge of and display competence about these important needs on the first day of transition.
    - Neither CLDP comprehensively specified needs for ongoing nursing oversight and/or monitoring. Instead, provider staff were to monitor for many conditions and contact the nurse immediately or within one hour if relevant signs/symptoms occurred. This was particularly concerning, because the pre-move training supports did not require provider staff other than the nurse to be trained in nursing needs or demonstrate competence for them.
    - Both individuals had a support for implementation of a bowel management plan, but the only specific expectation was for the nurse to be notified in the event of a lack of bowel movements and/or episodes of diarrhea within a specified time frame. The support did not specify any preventative bowel management strategies.
    - The OT/PT assessment for Individual #230 recommended OT/PT be available on a consultative basis, but the CLDP did not include a related support. Individual #720 also had needs in this area, but the IDT did not require any OT/PT monitoring or consultation.
    - Neither CLDP included supports that addressed supervision needs in a comprehensive manner.
        - Individual #230's CLDP did not include a supervision support.
        - Individual #720's CLDP did include a post-move support for 24-hour supervision to monitor for pica, attempted pica and inappropriate sexual behavior, and for one-to-one supervision in the community. This support had considerable detail, which was positive, but it did not provide clear expectations for regular bed-checks at night. The support indicated staff needed to ensure he was asleep before leaving his bedroom, but did not require that provider staff check periodically to ensure he remained asleep. This was important, because he sometimes managed to shred and ingest string from his pica blanket. At the Center, staff made 15-minute bed-checks overnight.
- What was important to the individual: The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. Neither CLDP assertively addressed these outcomes. Findings included:
    - The CLDPs indicated important outcomes for both individuals included becoming more independent,

remaining behaviorally and psychiatrically stable, maintaining the best physical health possible, and to go on an increased number of community outings. The IDTs did add some individualized indicators, so it was positive they made an effort to personalize this standard set of outcomes. Still, the IDTs needed to consider whether individuals had important preferred outcomes that fell outside these broad categories, such as for work and relationships. For example, Individual #720's ISP and PSI indicated he did not have actively involved family and would benefit from guardianship services. On 5/3/16, the IDT had processed a request for guardianship and was waiting for a possible Legally Authorized Representative (LAR) or advocate to be identified, which was still pending at the time of transition. The CLDP did not address this important outcome.

- Need/desire for employment, and/or other meaningful day activities: Neither CLDP met criterion, as described below:
  - Per the ISP, Individual #230 was employed at the work activity center on campus. Before working there, she had worked at a community workshop off-campus and at two restaurants rolling silverware. She continued this employment until the closure of these opportunities. The IDT documented she was physically capable of doing many tasks by herself and required little assistance after being shown how to do something. It further documented she liked working and wanted to continue. The ISP stated she should be exposed to other work opportunities that would use her natural strengths and preferences, with the goal to find paid or volunteer work in the community. The CLDP did not assertively address these strengths and goals. The CLDP included a support for Individual #230 to begin attending a day program within seven days of transition. It did not address either paid or volunteer work in an integrated setting. The CLDP narrative included a discussion about the possible availability of some paid work at a sheltered work setting, but the IDT did not include a support for this either. Another support indicated the provider would assist Individual #230 to attain several goals, one of which included finding employment in the community, but as described above, this support did not provide any measurable expectations about outcomes or timelines.
  - For Individual #720, the ISP discussion indicated the IDT agreed that working at the petting zoo would be a great experience. They identified a number of advantages to such a work setting, including that he would not have to sit all day, he would earn more money, he would get to interact with lots of different people, he liked dogs, and the exercise would assist him in losing weight. The IDT further indicated they would explore other work opportunities with Individual #720 and his job coach if the petting zoo did not work out and planned to do assessments of other possible work, such as in the maintenance area. The only CLDP support was, again, to begin attending an in-home day program within seven days of transition.
- Positive reinforcement, incentives, and/or other motivating components to an individual's success. For both individuals, the IDTs defined supports that included elements of positive reinforcement and other motivating components and met criterion. Both CLDPs provided specific pre-move and post-move behavioral and communication supports for providing contingent and non-contingent positive reinforcement on a daily basis.

- Teaching, maintenance, participation, and acquisition of specific skills: The respective IDTs developed some supports related to teaching, maintenance, participation, and acquisition of specific skills, but these were limited in scope and/or frequency. Findings included:
    - For Individual #230, the ISP described many skill acquisition needs, including identifying at least three street signs; identifying the symbols on a crosswalk sign; and, actively participating in the preparation of her food, including learning to use appliances such as blender, microwave, stove and oven, with a goal to make her own meals and snacks for a weekend. The IDT developed a single support for her to be provided with weekly opportunities to increase her independence, citing five possible options. These included some of the meal-related skills (using a microwave and preparing a snack), but did not include pedestrian safety or the use of other appliances. The IDT used the wording "such as, but not limited to" to describe these opportunities, however, and this left the expectation broad and open to interpretation.
    - For Individual #720, the IDT also developed a single support calling for opportunities to increase his independence. While this support also was hampered by its "such as but not limited to" construction, it was positive the IDT required daily rather than just weekly implementation. The Monitoring Team was concerned about the inclusion in this support of a specific skill acquisition plan to independently request a preferred item. This was supposed to have been a priority for implementation, but the wording of the support could have led community provider staff to consider it just one of many options.
- All recommendations from assessments are included, or if not, there is a rationale provided: Denton SSLC had a process in place for documenting in the CLDP discussion of assessments and recommendations, including the IDT's rationale for any changes to, or additional, recommendations. The Center had made significant improvement in its process for reviewing the discipline assessments for thoroughness, which was positive. Still, the IDTs did not consistently address recommendations with supports or otherwise provide a justification. Examples are described throughout this section above.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.	
Summary: Given that over the last two review periods and during this review, for the individuals reviewed, the Post-Move Monitor conducted timely monitoring (Round 11 – 100%, Round 12 – 100%, and Round 13 – 100%), Indicator 3 will move to the category requiring less oversight. Although the Post-Move Monitor generally paid good attention to detail, some of the areas in which continued efforts were needed related to the PMM consistently basing decisions about supports on reliable and valid data, the PMM correctly scoring the presence or absence supports based on the evidence, and developing a process to ensure that IDTs follow up in a timely and thorough manner when the PMM notes problems with the provision of supports. The remaining	Individuals:

indicators will continue in active oversight.											
#	Indicator	Overall Score	230	720							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	100% 2/2	1/1	1/1							
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1							
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1							
6	The PMM's assessment is correct based on the evidence.	0% 0/2	0/1	0/1							
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	0% 0/2	0/1	0/1							
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A	N/A	N/A							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A	N/A	N/A							

Comments: 3. Post-move monitoring was completed at required intervals for both individuals. Each of these post-move monitoring visits was within the required timeframes, was done in the proper format, and occurred at all locations where the individual lived or worked. For Individual #720, transition staff had also made an interim "pop-up" visit. Transition staff further reported adjusting PMM schedules depending on the needs of the individual, which was positive. For example, they noted one recently-transitioned individual received onsite PMM for seven straight days after moving to the community and was still being monitored three days a week to ensure a successful transition.

4. The Monitoring Team observed good progress in the efforts of the PMM to provide detailed comments describing

the status of supports. Still, PMM Checklists did not yet consistently provide valid and reliable data. To continue to move towards compliance, the Center should focus on improving the overall clarity and measurability of supports to provide guidance to the PMM as to what criteria would demonstrate their presence. Findings included, for example:

- In some supports, the language was broad and vague as described above with regard to Indicator #1, and did not provide the PMM with the needed clear criteria.
- Most of the CLDP supports required several prongs of evidence, including interviews, observations, and review of documentation, which was positive. Overall, the PMM was diligent and attentive to detail, but did not yet consistently address all the required prongs. This limited the reliability of the conclusions about whether supports were in place as needed. For example, Individual #720 had a behavioral support that included staff completing environmental sweeps for items he might ingest. The PMM Checklists did not reference this aspect of the support at any of the PMM visits,

5. Based on information the Post Move Monitor collected, both individuals had frequently received supports as listed and/or described in the CLDP, but this was not yet consistent. As described above, the Monitoring Team sometimes could not evaluate or confirm whether individuals had received supports due to the lack clarity and measurability in the supports as written and/or the lack of complete and reliable data. Examples of important supports not in place as required included the following:

- For Individual #230:
  - At the time of seven-day PMM visit, provider staff did not have knowledge of when to report a lack of bowel movements or at least three signs of hypoglycemia.
  - At the time of the 90-day PMM visit, provider staff could not state all requirements for what to do in the event of a seizure, signs/symptoms of gastritis, and signs/symptoms of hypoglycemia and hyperglycemia. Provider staff had not completed the required logs for blood pressure or blood sugar readings.
  - At the time of the 180-day PMM visit, provider staff were not aware of medications she received for diabetes and had not collected daily behavioral data.
- For Individual #720:
  - At the time of seven-day PMM visit, provider staff did not have full knowledge of the signs/symptoms of pleural effusion or constipation, and had not taken him to apply to become his representative payee. Provider staff had not completed behavioral data sheets correctly. The bed monitor was broken and needed to be replaced.
  - At the time of the 90-day PMM visit, the bed alarm was not in place. At the time of the pop-up visit following the 90-day PMM visit, the bed alarm was not working until the PMM notified the provider and the battery was replaced.
  - At the time of the pop-up visit, provider staff did not have full knowledge of the signs/symptoms of GERD.

6. Based on the supports defined in the CLDP, the Post-Move Monitor's scoring was often correct, but this was not

yet consistent. For example:

- At the time of the 45-day PMM visit for Individual #230, the PMM marked a support for behavioral data sheets as present, despite commenting the data sheets had not been filled out properly for a period of ten days immediately prior to the PMM visit. It was positive the PMM documented reminding the staff of the importance of filling the data sheets out, but the support should have been marked as not in place.
- Also, at the time of the 45-day PMM visit for Individual #230, the PMM documented six medication errors found in the medication administration records (MARs), but marked the support to provide medications as prescribed as in place.
- At the time of the 90-day PMM visit, Individual #720 had had a pica episode. The documentation indicated the provider RN had been contacted, but the PMM did not indicate whether lung sounds had been monitored as required. This was marked as in place.

7-8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed and that every problem is followed up through to resolution. Overall, the PMM was very diligent in completing timely follow-up with the provider when issues were accurately identified. Still, whether follow-up is completed as needed relies heavily on the accuracy of the PMM's assessment of whether supports were, or were not, in place; as described above, this was not yet consistent. In addition, the Center did not have a clearly stated policy about the process for IDT involvement in the review of PMM findings and outcomes. Denton SSLC should consider a consistent approach that would ensure the IDT will be able to weigh in on potential issues, such as emerging behaviors or changes to supports the provider might have implemented. For example, the IDT for Individual #720 should have been consulted about the provider's decision to discontinue his bed monitor, as that related to his pica safety precautions, and the decision of the community PCP to forgo some of his recommended labs.

9-10. The Monitoring Team did not observe the post-move monitoring during this site visit, so these indicators were not scored.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.												
Summary: Neither individual had experienced a PDCT event. This indicator will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	230	720								
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to	100% 2/2	1/1	1/1								

	identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.										
Comments: 11. Neither individual had experienced a PDCT event.											

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.											
Summary: Given that over the last two review periods and during this review, for the individuals reviewed, IDT members actively participated in the transition planning process, the CLDP specified the staff responsible and timeframes for transition actions, and the CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making (Round 11 – 100%, Round 12 – 100%, and Round 13 – 100%), Indicator 13 will move to the category requiring less oversight. It was positive transition staff worked with several disciplines on the quality of transition assessments and recommendations. Some progress was observed, but additional improvement was needed in the completion of all needed assessments, as well as the inclusion of comprehensive and community-appropriate recommendations. Although Center staff provided training to community provider staff, the CLDPs did not define the training thoroughly, and Center staff still were not able to confirm that community provider staff were competent to meet individuals' needs at the time of transition. The remaining indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	230	720							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to	100% 2/2	1/1	1/1							

	be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.										
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 0/2	0/1	0/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/2	0/1	0/1							
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.	100% 2/2	1/1	1/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0% 0/1	0% 0/1							

Comments: 12. Assessments did not consistently meet criterion for this indicator. It was positive transition staff had been working with several disciplines on the quality of transition assessments and recommendations. Some progress was observed, but additional improvement was needed in the area of ensuring comprehensive and community-appropriate recommendations. The Monitoring Team considers the following four sub-indicators when evaluating compliance:

- Assessments updated with 45 Days of transition:
  - The IDTs did not provide updated Quarterly Drug Regimen Reviews (QDRRs) or Integrated Risk Rating Forms (IRRFs) for these two CLDPs.
  - Otherwise, assessments for Individual #230 consistently met criterion for timeliness,
  - For Individual #720, the transition date had been delayed for approximately two months. This resulted in a need for transition assessments to be reviewed and updated as needed within the 45-day window. Most of the assessments did receive the required updates, but this did not include the nursing or OT/PT assessments. In addition, Individual #720's day programming assessment provided was dated 9/27/16, which was almost a year old.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Assessments did not consistently meet criterion, although this was an area of improvement overall.

- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments that had been updated did not yet thoroughly provide recommendations to support transition. For example, the communication assessment for Individual #230 included a recommendation that she have communication assessments "as indicated."
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not fully address/focus on the new community home and day/work settings. Assessments did not consistently meet criterion in this area. With regard to community-focused supports, at times, assessors will be able to identify an appropriate community alternative to match a support provided at the Center, and in other instances, they will need to recommend working with the community provider at the CLDP meeting to determine how Center-specific supports can be translated to community supports. For example, token economies, or PNMPs might need to look different in the community. In other instances, supports will need to be developed to address differences between Center-living, and community living. For example, more staffing supports or training might be necessary to compensate for the difference in speed limits on Center campuses, as opposed to in the community.

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator, including the following: 1) There was documentation to show IDT members actively participated in the transition planning process; 2) the CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed; 3) the CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting. Both CLDPs met criterion for this indicator. In addition to the detailed Transition Logs, Section IV of the CLDP document, entitled Community Living, provided a summary of transition activities that described the involvement of the individual and LAR/ family, the LIDDA, and Center staff. These were helpful in understanding how the Center's transition processes ensured necessary participation.

14. Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required: Training provided to community provider staff did not yet meet criterion for these two CLDPs. Findings included:

- Although there was progress in this area, the IDTs did not yet consistently identify the expected provider staff knowledge or competencies that needed to be demonstrated.
- As described with regard to Indicator #1, the IDT did not demonstrate that it considered the types of training methodologies that would be most appropriate to the needs described in the supports.
- The Center's approach to assuring that pre-move training produced provider staff competence was inconsistent. The IDTs did not provide evidence of competency testing for all supports. For those that did evidence the administration of testing, the IDT did not construct these to measure the specific criteria that would demonstrate staff were competent to provide supports as required. The tests reviewed did not include questions for many of the topics and/or competencies listed as needed under each support, so there was no evidence that confirmed related staff knowledge.

- The Monitoring Team was concerned that Individual #720's CLDP only included supports for training the provider home director/RN and did not specify how provider staff who would be responsible for delivering the day-to-day supports would be trained or their competency confirmed.

15. When necessary, Center staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: For both individuals, the IDT developed pre-move supports for a doctor-to-doctor consultation and specified the topic areas that needed to be included. The documentation for Individual #230 reflected a thorough and timely consultation. For Individual #720, this documentation was minimal, indicating only that diagnoses were to be covered. For Individual #230, a recommendation for no changes to psychiatric medications without first consulting with the BCBA and medical professionals might have also indicated a need for a pre-move collaboration between the Center and community psychiatrists. It was positive transition staff reported more recent CLDPs were frequently addressing additional clinician-to-clinician consultations that might be needed to ensure a successful transition.

16. SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs: The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs. Neither of these CLDPs provided the required description.

17. Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual: The CLDP should include a specific statement of IDT considerations of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results. Examples include provider direct support staff spending time at the Center, Center direct support staff spending time with the individual in the community, and Center and provider direct support staff meeting to discuss the individual's needs.

- The Transition Log for Individual #230 documented that provider staff came to campus for an in-service training on nursing, habilitation, and behavioral needs. The IDT did not document whether this included participation by any provider and/or Center direct support staff. The Transition Log did indicate preferred direct support staff accompanied Individual #230 when she began her transitional visit. This was positive. The IDT still needed to provide the specific summary statement of the considerations it undertook in this area as well as a description of the results.
- For Individual #720, the Transition Log also documented that provider staff came to campus for an in-service training, but did not describe whether this included participation by any provider and/or Center direct support staff. The IDT needed to provide the specific summary statement of the considerations it undertook in this area as well as a description of the results.

18. The APC and transition department staff collaborates with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition: Both CLDPs met criterion. Transition staff also reported they continued to hold a quarterly LIDDA meeting to ensure ongoing communication and

coordination. This was a positive practice.

19. The pre-move site reviews (PMSRs) for both individuals were completed prior to the transition date. It is essential the Center directly affirms provider staff competency to ensure an individual's health and safety prior to relinquishing day-to-day responsibility, but the neither of these two PMSRs accomplished this. Examples of concerns from this review included:

- For both individuals, the PMM relied upon implementation of pre-move training supports to confirm provider staff were prepared to implement supports as needed. As described above regarding Indicator 1 and Indicator 14, the CLDPs included numerous pre-move supports for pre-move training, but these did not yet fully meet criterion for ensuring that provider staff were competent for either individual.
- For Individual #230, the pre-move in-service supports indicated provider staff should be interviewed at every visit, but the PMSR did not document interviews to confirm staff knowledge; instead it documented only a review of in-service signature sheets. Attendance at a training does not suffice as evidence of staff knowledge/competence.
- For Individual #720, it was positive the pre-move site review documented staff interviews regarding competence related to most of the pre-move training. The only exception was for the pre-move training support for the PBSP. This support included only a description of what was to be included in the training, and did not include any testing of staff competence. Another pre-move support for the doctor-to-doctor consult specified the information that was to be included, including active diagnoses, current medication/treatments, labs, follow-up, need for annual EKG, an eye exam, and any other information needed to provide comprehensive medical care. The PMSR documented that the consult was completed and signed. It did not document the required content was included. However, this was not accurate. The evidence the Monitoring Team reviewed indicated only diagnoses were to be covered, and that at the time of the transition, the community PCP declined the consult.

Outcome 5 – Individuals have timely transition planning and implementation.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	230	720							
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	50% 1/2	1/1	0/1							

Comments: 20. One of two CLDPs met criterion for this indicator.

- On 7/14/16, Individual #230 was referred, and on 7/13/17, she transitioned. This exceeded 180 days, but the Transition Log documented ongoing activity.
- On 10/17/16, Individual #720 was referred, and on 9/6/17, he transitioned. This also exceeded 180 days. The transition was originally scheduled for 7/11/17, but on 7/7/17, the IDT realized it needed to document

	its rationale for requesting one-to-one supervision and a Level of Need (LON) 9. This required several steps and the IDT had to postpone the transition date nearly two months to complete them. Going forward, transition staff reported the IDTs will identify such needs at the time of the 14-day meeting so they can be addressed earlier in the process.

APPENDIX A – Interviews and Documents Reviewed

Interviews: Interviews were conducted of individuals, direct support professionals, nursing, medical, and therapy staff.

Documents:

- List of all individuals by residence, including date of birth, date of most recent ISP, date of prior ISP, date current ISP was filed, name of PCP, and the name of the QIDP;
- In alphabetical order: All individuals and their at-risk ratings (i.e., high, medium, or low across all risk categories), preferably, this should be a spreadsheet with individuals listed on the left, with the various risk categories running across the top, and an indication of the individual's risk rating for each category;
- All individuals who were admitted since the last review, with date of admission;
- Individuals transitioned to the community since the last review;
- Community referral list, as of most current date available;
- List of individuals who have died since the last review, including date of death, age at death, and cause(s) of death;
- List of individuals with an ISP meeting, or a ISP Preparation meeting, during the onsite week, including name and date/time and place of meeting;
- Schedule of meals by residence;
- For last year, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit);
- For last year, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay);
- Lists of:
    - All individuals assessed/reviewed by the PNMT to date;
    - Current individuals on caseload of the PNMT, including the referral date and the reason for the referral to the PNMT;
    - Individuals referred to the PNMT in the past six months;
    - Individuals discharged by the PNMT in the past six months;
    - Individuals who receive nutrition through non-oral methods. For individuals who require enteral feeding, please identify each individual by name, living unit, type of feeding tube (e.g., G-tube, J-tube), feeding schedule (e.g., continuous, bolus, intermittent, etc.), the date that the tube was placed, and if the individual is receiving pleasure foods and/or a therapeutic feeding program;
    - Individuals who received a feeding tube in the past six months and the date of the tube placement;
    - Individuals who are at risk of receiving a feeding tube;
    - In the past six months, individuals who have had a choking incident requiring abdominal thrust, date of occurrence, and what they choked on;
    - In the past six months, individuals who have had an aspiration and/or pneumonia incident and the date(s) of the hospital, emergency room and/or infirmary admissions;
    - In the past six months, individuals who have had a decubitus/pressure ulcer, including name of individual, date of onset, stage, location, and date of resolution or current status;

  - In the past six months, individuals who have experienced a fracture;
  - In the past six months, individuals who have had a fecal impaction or bowel obstruction;
  - Individuals' oral hygiene ratings;
  - Individuals receiving direct OT, PT, and/or speech services and focus of intervention;
  - Individuals with Alternative and Augmentative Communication (ACC) devices (high and low tech) and/or environmental control device related to communication, including the individual's name, living unit, type of device, and date device received;
  - Individuals with PBSPs and replacement behaviors related to communication;
  - Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
  - In the past six months, individuals that have refused dental services (i.e., refused to attend a dental appointment or refused to allow completion of all or part of the dental exam or work once at the clinic);
  - Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
  - In the past six months, individuals with dental emergencies;
  - Individuals with Do Not Resuscitate Orders, including qualifying condition; and
  - In the past six months, individuals with adverse drug reactions, including date of discovery.
- Lists of:
  - Crisis intervention restraints.
  - Medical restraints.
  - Protective devices.
  - Any injuries to individuals that occurred during restraint.
  - HHSC PI cases.
  - All serious injuries.
  - All injuries from individual-to-individual aggression.
  - All serious incidents other than ANE and serious injuries.
  - Non-serious Injury Investigations (NSIs).
  - Lists of individuals who:
    - Have a PBSP
    - Have a crisis intervention plan
    - Have had more than three restraints in a rolling 30 days
    - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
    - Were reviewed by external peer review
    - Were reviewed by internal peer review
    - Were under age 22
  - Individuals who receive psychiatry services and their medications, diagnoses, etc.

- A map of the Facility

- An organizational chart for the Facility, including names of staff and titles for medical, nursing, and habilitation therapy departments
- Episode Tracker
- For last year, in alphabetical order by individual, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit)
- For last year, in alphabetical order by individual, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay)
- Facility policies related to:
    a. PNMT
    b. OT/PT and Speech
    c. Medical
    d. Nursing
    e. Pharmacy
    f. Dental
- List of Medication times by home
- All DUE reports completed over the last six months (include background information, data collection forms utilized, results, and any minutes reflecting action steps based on the results)
- For all deaths occurring since the last review, the recommendations from the administrative death review, and evidence of closure for each recommendation (please match the evidence with each recommendation)
- Last two quarterly trend reports regarding allegations, incidents, and injuries.
- QAQI Council (or any committee that serves the equivalent function) minutes (and relevant attachments if any, such as the QA report) for the last two meetings in which data associated with restraint use and incident management were presented and reviewed.
- The facility's own analysis of the set of restraint-related graphs prepared by state office for the Monitoring Team.
- The DADS report that lists staff (in alphabetical order please) and dates of completion of criminal background checks.
- A list of the injury audits conducted in the last 12 months.
- Polypharmacy committee meeting minutes for last six months.
- Facility's lab matrix
- Names of all behavioral health services staff, title/position, and status of BCBA certification.
- Facility's most recent obstacles report.
- A list of any individuals for whom you've eliminated the use of restraint over the past nine months.
- A copy of the Facility's guidelines for assessing engagement (include any forms used); and also include engagement scores for the past six months.
- Calendar-schedule of meetings that will occur during the week onsite.

The individual-specific documents listed below:

- ISP document, including ISP Action Plan pages
- IRRF, including revisions since the ISP meeting
- IHCP

- PNMP, including dining plans, positioning plans, etc. with all supporting photographs used for staff implementation of the PNMP
- Most recent Annual Medical Assessment, including problem list(s)
- Active Problem List
- ISPAs for the last six months
- QIDP monthly reviews/reports, and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request
- QDRRs: last two, including the Medication Profile
- Any ISPAs related to lack of progress on ISP Action Plans, including IHCP action plans
- PNMT assessment, if any
- Nutrition Assessment(s) and consults within the last 12 months
- IPNs for last six months, including as applicable Hospitalization/ER/LTAC related records, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, Restraint Checklists Pre- and Post-Sedation, etc.
- ED transfer sheets, if any
- Any ED reports (i.e., not just the patient instruction sheet)
- Any hospitalization reports
- Immunization Record from the active record
- AVATAR Immunization Record
- Consents for immunizations
- Medication Variance forms and follow-up documentation for the last six months (i.e., include the form and Avatar Report)
- Annual Nursing Assessment, and associated documents (e.g., Braden Scale, weight record)
- Last two quarterly nursing assessments, and associated documents (e.g., Braden Scale, weight record)
- Acute care plans for the last six months
- Direct Support Professional Instruction Sheets, and documentation validating direct support professionals training on care plans, including IHCPs, and acute care plans
- Last three months Eternal Nutrition Flow Record, if applicable
- Last three months Aspiration Trigger Sheets, if applicable
- Last three months Bowel Tracking Sheets (if medium or high risk for constipation and bowel obstruction requiring a plan of care)
- Last three months Treatment Records, including current month
- Last three months Weight records (including current month), if unplanned weight gain or loss has occurred requiring a plan of care
- Last three months of Seizure Records (including current month) and corresponding documentation in the IPN note, if applicable
- To show implementation of the individual’s IHCP, any flow sheets or other associated documentation not already provided in previous requests
- Last six months of Physician Orders (including most recent quarter of medication orders)
- Current MAR and last three months of MARs (i.e., including front and back of MARs)
- Last three months Self Administration of Medication (SAMs) Program Data Sheets, as implemented by Nursing
- Adverse Drug Reaction Forms and follow-up documentation

- For individuals that have been restrained (i.e., chemical or physical), the Crisis Intervention Restraint Checklist, Crisis Intervention Face-to-Face Assessment and Debriefing, Administration of Chemical Restraint Consult and Review Form, Physician notification, and order for restraint
- Signature page (including date) of previous Annual Medical Assessment (i.e., Annual Medical Assessment is requested in #5, please provide the previous one's signature page here)
- Last three quarterly medical reviews
- Preventative care flow sheet
- Annual dental examination and summary, including periodontal chart, and signature (including date) page of previous dental examination
- For last six months, dental progress notes and IPNs related to dental care
- Dental clinic notes for the last two clinic visits
- For individuals who received medical and/or dental pre-treatment sedation, all documentation of monitoring, including vital sign sheets, and nursing assessments, if not included in the IPNs.
- For individuals who received general anesthesia/TIVA, all vital sign flow sheets, monitoring strips, and post-anesthesia assessments
- For individuals who received TIVA or medical and/or dental pre-treatment sedation, copy of informed consent, and documentation of committee or group discussion related to use of medication/anesthesia
- ISPAs, plans, and/or strategies to address individuals with poor oral hygiene and continued need for sedation/TIVA
- For any individual with a dental emergency in the last six months, documentation showing the reason for the emergency visit, and the time and date of the onset of symptoms
- Documentation of the Pharmacy's review of the five most recent new medication the orders for the individual
- WORx Patient Interventions for the last six months, including documentation of communication with providers
- When there is a recommendation in patient intervention or a QDRR requiring a change to an order, the order showing the change was made
- Adverse Drug Reaction Forms and follow-up documentation
- PCP post-hospital IPNs, if any
- Post-hospital ISPAs, if any
- Medication Patient Profile form from Pharmacy
- Current 90/180-day orders, and any subsequent medication orders
- Any additional physician orders for last six months
- Consultation reports for the last six months
- For consultation reports for which PCPs indicate agreement, orders or other documentation to show follow-through
- Any ISPAs related to consultation reports in the last six months
- Lab reports for the last one-year period
- Most recent colonoscopy report, if applicable
- Most recent mammogram report, if applicable
- For eligible women, the Pap smear report

- DEXA scan reports, if applicable
- EGD, GES, and/or pH study reports, if applicable
- Most recent ophthalmology/optometry report
- The most recent EKG
- Most recent audiology report
- Clinical justification for Do Not Resuscitate Order, if applicable
- For individuals requiring suction tooth brushing, last two months of data showing implementation
- PNMT referral form, if applicable
- PNMT minutes related to individual identified for the last 12 months, if applicable
- PNMT Nurse Post-hospitalization assessment, if applicable
- Dysphagia assessment and consults (past 12 months)
- IPNs related to PNMT for the last 12 months
- ISPAs related to PNMT assessment and/or interventions, if applicable
- Communication screening, if applicable
- Most recent Communication assessment, and all updates since that assessment
- Speech consultations, if applicable
- Any other speech/communication assessment if not mentioned above, if any within the last 12 months
- ISPAs related to communication
- Skill Acquisition Programs related to communication, including teaching strategies
- Direct communication therapy plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to communication
- Communication dictionary
- IPNs related to speech therapy/communication goals and objectives
- Discharge documentation for speech/communication therapy, if applicable
- OT/PT Screening
- Most recent OT/PT Assessment, and all updates since that assessment
- OT/PT consults, if any
- Head of Bed Assessment, if any within the last 12 months
- Wheelchair Assessment, if any within the last 12 months
- Any other OT/PT assessment if not mentioned above, if any within the last 12 months
- ISPAs related to OT/PT
- Any PNMPs implemented during the last six months
- Skill Acquisition Programs related to OT/PT, including teaching strategies
- Direct PT/OT Treatment Plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to OT/PT

- IPNs related to OT/PT goals and objectives
- Discharge documentation for OT/PT therapy, if applicable
- REISS screen, if individual is not receiving psychiatric services

The individual-specific documents listed below:

- ISP document
- IRRF, including any revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment
- Active Problem List
- All ISPAs for past six months
- QIDP monthly reviews/reports (and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request)
- QDRRs: last two
- List of all staff who regularly work with the individual and their normal shift assignment
- ISP Preparation document
- These annual ISP assessments: nursing, habilitation, dental, rights
- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment
- Functional Skills Assessment and FSA Summary
- PSI
- QIDP data regarding submission of assessments prior to annual ISP meeting
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained
- Crisis Intervention Plan
- Protective mechanical restraint plan
- Medical restraint plan
- All skill acquisition plans (SAP) (include desensitization plans
- SAP data for the past three months (and SAP monthly reviews if different)
- All Service Objectives implementation plans
- Comprehensive psychiatric evaluation (CPE)
- Annual CPE update (or whatever document is used at the facility)
- All psychiatry clinic notes for the past 12 months (this includes quarterlies as well any emergency, urgent, interim, and/or follow-up

clinic notes)
- Reiss scale
- MOSES and DISCUS forms for past six months
- Documentation of consent for each psychiatric medication
- Psychiatric Support Plan (PSP)
- Neurology consultation documentation for past 12 months
- For any applications of PEMA (psychiatric emergency medication administration), any IPN entries and any other related documentation.
- Listing of all medications and dosages.
- If any pretreatment sedation, date of administration, IPN notes, and any other relevant documentation.
- If admitted after 1/1/14, IPNs from day of admission and first business day after day of admission.
- Behavioral health/psychology monthly progress notes for past six months.
- Current ARD/IEP, and most recent progress note or report card.
- For the past six months, list of all training conducted on PBSP
- For the past six months, list of all training conducted on SAPs
- A summary of all treatment integrity/behavior drills and IOA checks completed for PBSPs.
- A summary of all treatment integrity/behavior drills and IOA checks completed for skill acquisition programs from the previous six months.
- Description/listing of individual's work program or day habilitation program and the individual's attendance for the past six months.
- Data that summarize the individual's community outings for the last six months.
- A list of all instances of formal skill training provided to the individual in community settings for the past six months.
- The individual's daily schedule of activities.
- Documentation for the selected restraints.
- Documentation for the selected HHSC PI investigations for which the individual was an alleged victim,
- Documentation for the selected facility investigations where an incident involving the individual was the subject of the investigation.
- A list of all injuries for the individual in last six months.
- Any trend data regarding incidents and injuries for this individual over the past year.
- If the individual was the subject of an injury audit in the past year, audit documentation.

For specific individuals who have moved to the community:
- ISP document (including ISP action plan pages)
- IRRF
- IHCP
- PSI
- ISPAs
- CLDP

- Discharge assessments
- Day of move checklist
- Post move monitoring reports
- PDCT reports
- Any other documentation about the individual’s transition and/or post move incidents.

APPENDIX B - List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ADR	Adverse Drug Reaction
ADL	Adaptive living skills
AED	Antiepileptic Drug
AMA	Annual medical assessment
APC	Admissions and Placement Coordinator
APRN	Advanced Practice Registered Nurse
ASD	Autism Spectrum Disorder
BHS	Behavioral Health Services
CBC	Complete Blood Count
CDC	Centers for Disease Control
CDiff	Clostridium difficile
CLDP	Community Living Discharge Plan
CNE	Chief Nurse Executive
CPE	Comprehensive Psychiatric Evaluation
CPR	Cardiopulmonary Resuscitation
CXR	Chest x-ray
DADS	Texas Department of Aging and Disability Services
DNR	Do Not Resuscitate
DOJ	Department of Justice
DSHS	Department of State Health Services
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
EC	Environmental Control
ED	Emergency Department
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
ENT	Ear, Nose, Throat
FSA	Functional Skills Assessment
GERD	Gastroesophageal reflux disease
GI	Gastroenterology
G-tube	Gastrostomy Tube
Hb	Hemoglobin

HCS	Home and Community-based Services
HDL	High-density Lipoprotein
HRC	Human Rights Committee
ICF/IID	Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions
IDT	Interdisciplinary Team
IHCP	Integrated Health Care Plan
IM	Intramuscular
IMC	Incident Management Coordinator
IOA	Inter-observer agreement
IPNs	Integrated Progress Notes
IRRF	Integrated Risk Rating Form
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IV	Intravenous
LVN	Licensed Vocational Nurse
LTBI	Latent tuberculosis infection
MAR	Medication Administration Record
mg	milligrams
ml	milliliters
NMES	Neuromuscular Electrical Stimulation
NOO	Nursing Operations Officer
OT	Occupational Therapy
P&T	Pharmacy and Therapeutics
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PDCT	Potentially Disrupted Community Transition
PEG-tube	Percutaneous endoscopic gastrostomy tube
PEMA	Psychiatric Emergency Medication Administration
PMM	Post Move Monitor
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PRN	pro re nata (as needed)
PT	Physical Therapy
PTP	Psychiatric Treatment Plan
PTS	Pretreatment sedation

QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
RDH	Registered Dental Hygienist
RN	Registered Nurse
SAP	Skill Acquisition Program
SO	Service/Support Objective
SOTP	Sex Offender Treatment Program
SSLC	State Supported Living Center
TIVA	Total Intravenous Anesthesia
TSH	Thyroid Stimulating Hormone
UTI	Urinary Tract Infection
VZV	Varicella-zoster virus